

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. John Kehoe, Medical examiner notified & approved

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15773

CERTIFICATE OF DEATH

15771

1. PLACE OF DEATH a. COUNTY <b>Pro Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Carrollton Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Carrollton, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8318 Nicholson st</b>		d. STREET ADDRESS <b>8318 Nicholson st</b>	
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>H.</b> Last <b>ALLEN</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>14,</b> Year <b>19 67</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 12, 1882</b>
9. AGE (In years last birthday) yrs. <b>85</b>		10. IF UNDER 1 YEAR Months <b>14,</b> Days <b>19</b> Hours <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Jerome Beron</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Tschsaelli</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Amelia Morton</b>		Address <b>New Carrollton, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC-RESPIRATORY FAILURE</b> DUE TO (b) <b>ACUTE PULMONARY EDEMA</b> DUE TO (c) <b>SEVERE ARTERIOSCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/4</b> , 19 <b>67</b> , to <b>11/14</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>11/11</b> , 19 <b>67</b> , and that death occurred at <b>4 P.</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <b>Max M. Herzberg</b>		22b. DATE SIGNED <b>Nov 14, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>MAX M. HERZBERG</b>		22d. ADDRESS <b>3308 Lodge Park Rd Landover, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 17, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>NOV 17 1967</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15780

15772

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington, D. C.</b> b. COUNTY <b>47-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>1yr., 1 1/2 mos.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>1850 Potomac Ave., S. E.</b>	
3. NAME OF DECEASED (Type or print) First <b>Augustus</b> Middle <b>--</b> Last <b>Anderson</b>		4. DATE OF DEATH Month <b>11</b> Day <b>7</b> Year <b>19 67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/15/1889</b>
9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>? retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>S. C. (Sumter)</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hardy Anderson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jennings</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331 X</b> DUE TO <b>Cerebrovascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO <b>Cerebral arteriosclerosis</b> (c) DUE TO <b>Generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cor pulmonale due to pulmonary emphysema and bronchial asthma</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9/23/</b> , 19 <b>66</b> , to <b>11/7/</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/7/</b> 19 <b>67</b> , and that death occurred at <b>7:40 P.</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>11/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11-13-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY MEMORIAL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>PRINCE GEORGE'S, MARYLAND</b>
24. FUNERAL DIRECTOR <b>John T. Ramesco</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 13 1967</b>	
ADDRESS <b>30 N-1/2 St. 76</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

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15773

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro Geo</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>6819 Ingraham st</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Allan</b> Last <b>Anderson</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>28</b> Year <b>19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1914</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>17</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Public relations</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Allan Anderson</b>		14. MOTHER'S MAIDEN NAME <b>Hilda Hepz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Evelyn W Anderson</b>		Address <b>Cheverly, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Accident</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9-6</b> , 19 <b>67</b> , to <b>11-28</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-21</b> , 19 <b>67</b> , and that death occurred at <b>7:55A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Robert D. Deitz, M.D.</b>		22b. DATE SIGNED <b>11/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert D. Deitz, M.D.</b>		22d. ADDRESS <b>Prince George's Plaza</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec 1, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>Nov 30 1967</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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Notary Public when issued

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G395 11/29/67 pn  
Item 23b, telephone call - Gasch's S. H. 12/21/67 cad

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>4 days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			d. STREET ADDRESS <b>Enterprise Road</b>		
3. NAME OF DECEASED (Type or print) First <b>Lloyd</b> Middle <b>E</b> Last <b>Anderson</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>22</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Oct. 1909</b>		9. AGE (In years last birthday) <b>58</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W S S D</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Albert Anderson</b>			14. MOTHER'S MAIDEN NAME <b>Mae Moffett</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>579 16 4554</b>		17. INFORMANT <b>Helen D. Anderson</b> Address <b>Mitchellville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Undetermined</b> <b>7955</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 18, 1967</b> , to <b>Nov. 22, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 22, 1967</b> , and that death occurred at <b>6.00 AM</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Arnold G. Brody, M.D.</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Nov 22-1967</b>
22c. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M.D.</b>			22d. ADDRESS <b>Prince Georges General Hospital</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE OF REMOVAL <b>Nov 18, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>		
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>			25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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### References

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

Item #9 Film #G394 11/9/67 ph

**CERTIFICATE OF DEATH**

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1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>			c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PRINCE GEORGE GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>5903 EUCLID ST.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>G.</b> Last <b>ANDREWS SR.</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>4</b> Year <b>1967</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAU.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>16 NOV. 1915</b>	
				9. AGE (In years last birthday) <b>51 52</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PSYCHOLOGY</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>UNI. of Maryland</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Neb.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
13. FATHER'S NAME <b>HENRY C. ANDREWS</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET HUBBARD</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>126-14-2986</b>		17. INFORMANT Address <b>Vivian N. Andrews, Wife, same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>coronary thrombosis</b> DUE TO (c) <b>arteriosclerotic heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 hr</b> <b>1 hr</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 14, 1962</b> to <b>Nov. 4th, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 24, 1967</b> , and that death occurred at <b>8:30 PM</b> , from causes on and on the date stated above.							
22a. SIGNATURE <b>Till Bergemann</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/5/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Till Bergemann, M. D.</b>				22d. ADDRESS <b>Greenbelt, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/7/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>COLMAR MANOR MARYLAND</b>	
24. FUNERAL DIRECTOR <b>GASCH'S Funeral Home</b>				ADDRESS <b>HYATTSVILLE, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 7 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

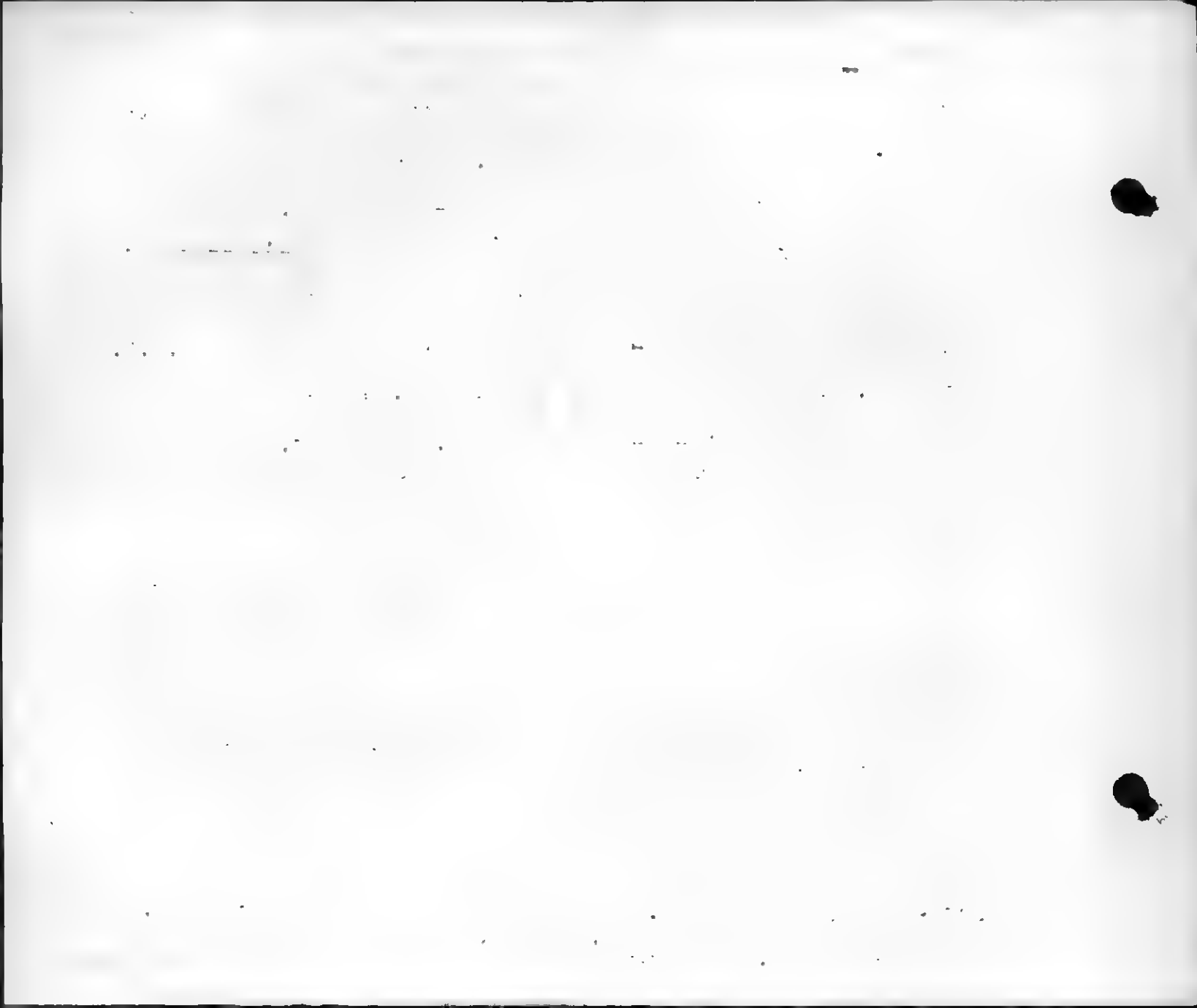
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
		d. STREET ADDRESS 3924 - Wells Ave.	
3. NAME OF DECEASED (Type or print) Sarah Adeline APPELL		4. DATE OF DEATH Nov 1, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/20/1880
9. AGE (In years last birthday) 87		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mason E. Young		14. MOTHER'S MAIDEN NAME Mollie D. Sheets	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-09-6659	
17. INFORMANT Address Arthur W. Appell Jr. (above address)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema (Sond) DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 28, 1967, to Oct 31, 1967, that I last saw the deceased alive on Oct. 31, 1967, and that death occurred at 5 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. B. Cameron		ADDRESS (Street, city or town, state) DATE SIGNED Nov. 1, 1967	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/4/67	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier, Maryland	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE NOV 6 1967			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained at hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15785

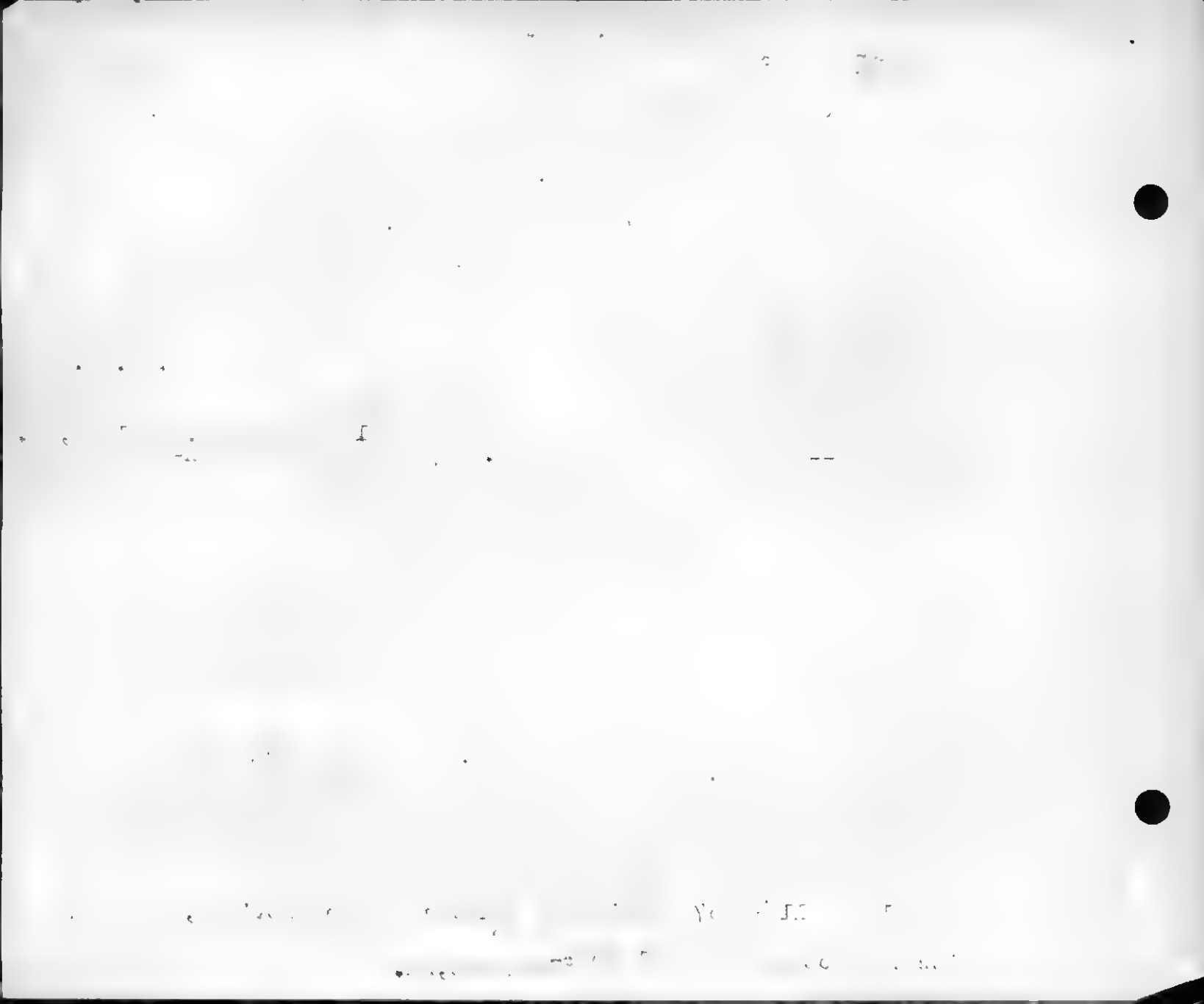
CERTIFICATE OF DEATH

17413

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>4-1/2 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived if institut on Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>Rt. 301, Box 4775</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lewis</b> Middle <b>G.</b> Last <b>Armstrong</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/2/1894</b>
9. AGE (In years lost birthday) <b>73</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <b>Tobacco Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Parsons Armstrong</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Anderson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown --</b>		16. SOCIAL SECURITY NO. <b>8401 Wexford Rd., Marlton, Md.</b>	
17. INFORMANT <b>Mrs. Mary Armstrong Gatton-</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Hemorrhagic Pancreatitis</b> DUE TO <b>Biliary Obstruction</b> (b) <b>(Calculus in ampulla of Vater)</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>(c)</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 24</b> , 19 <b>67</b> , to <b>Nov. 24</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov. 24</b> , 19 <b>67</b> , and that death occurred on <b>11:00 AM</b> from causes on and on the date stated above			
22a. SIGNATURE <b>Oliver B. Bond</b>		22b. DATE SIGNED <b>11-25-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>OLIVER B. BOND</b>		22d. ADDRESS <b>6872 RIVERDALE ROAD LANHAM MARYLAND 20801</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/29/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Forestville, Maryland</b>
24. FUNERAL DIRECTOR <b>Ritchie Brothers Funeral Homes</b>		25a. REC'D BY REGISTRAR <b>DEC 8 1967</b>	
ADDRESS <b>Upper Marlboro, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

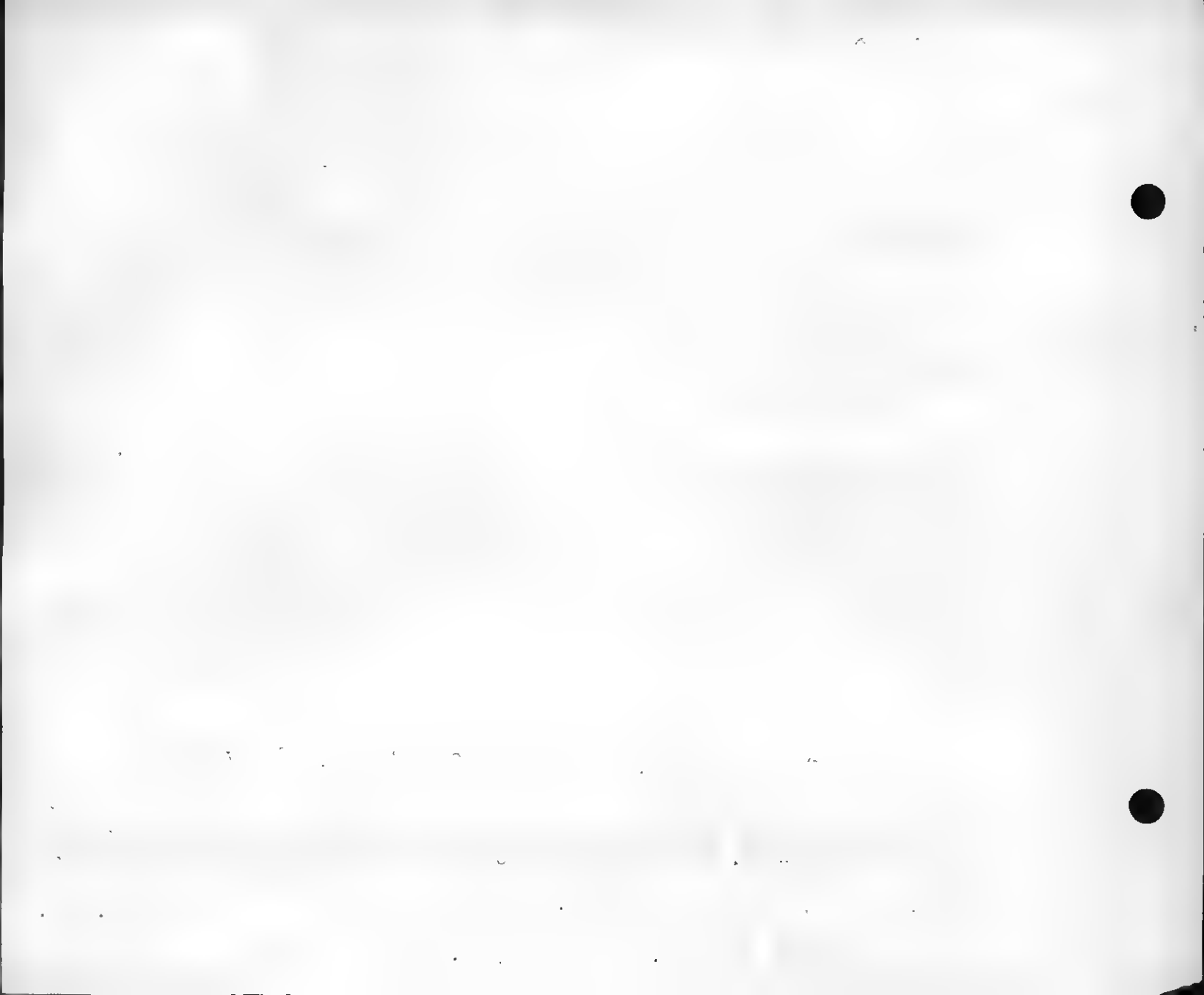
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>		c. LENGTH OF STAY IN 1b <b>18 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MALCOLM GROW USAF HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>ROSE</b> Middle <b>M</b> Last <b>BAKER</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>11</b> Year <b>19 67</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 SEPT 1894</b>
9 AGE (In years last birthday) <b>73</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE RETIRED</b>	11. BIRTHPLACE (County & State, or foreign country) <b>CASTLEWOOD VA</b>
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>NELSON (NMI) MOORE</b>	
14. MOTHER'S MAIDEN NAME <b>CYNTHIA E NYE</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16 SOCIAL SECURITY NO		17. INFORMANT <b>RALPH B NICHOLS</b> Address <b>7210 OXON HILL RD. OXON HILL MD</b>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21 I certify that <del>he</del> (this hospital) attended the deceased from <b>24 October 19 67</b> to <b>11 November 19 67</b> , that (I) (we) last saw the deceased alive on <b>11 November 19 67</b> , and that death occurred at <b>0525 M</b> , from causes and on the date stated above			
22a. SIGNATURE <i>Leonard R. Farber</i>		22b DATE SIGNED <b>11 NOV 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEONARD R. FARBER CAPT USAF MC</b>		22d. ADDRESS <b>Malcolm Grow USAF Hospital Maryland</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11/13/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Baker Ridge Cemetery</b>	23d LOCATION (City or town) (County) (State) <b>Russell Co., Va.</b>
24 FUNERAL DIRECTOR <b>Walter J. Hall</b> <b>Cunningham Funeral Home Inc. Alexandria, Va.</b>		25a REC'D BY REGISTRAR <b>DAVID 14 1967</b>	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15787

**CERTIFICATE OF DEATH**

15778

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>					
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Riverdale</b>			c. LENGTH OF STAY IN It			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>						d. STREET ADDRESS <b>4800 Hollywood Rd.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Francis</b> First <b>G.</b> Middle <b>Baldwin</b> Last				4. DATE OF DEATH Month <b>11-13-67</b> Day Year 19 <b>67</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-30-03</b>		9. AGE (In years last birthday) <b>63</b> yrs	
						IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Francis P. Baldwin</b>				14. MOTHER'S MAIDEN NAME <b>Elsie Pickett</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Spouse &amp; Medical Records</b> Address			
MEDICAL CERTIFICATION 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> +201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <b>67</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-11</u> , 19 <u>67</u> , to <u>11-13</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>11-13</u> , 19 <u>67</u> , and that death occurred at <u>10</u> A.M. from causes and on the date stated above.									
22a. SIGNATURE <u>DR Purdie</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>DONALD R. PURDIE</u>						22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-16-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Garage Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Garage Highway Md.</u>			
24. FUNERAL DIRECTOR <u>Be Witt Donaldson Lunsel, m.d.</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>NOV 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15783

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15779

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesverly</b>		c. LENGTH OF STAY IN 1b <b>5 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George</b>				d. STREET ADDRESS <b>Box 274</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Wesley Barkley</b>				4. DATE OF DEATH Month Day Year <b>11 2 1967</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>28 July 1911</b>	9. AGE (In years last birthday) yrs <b>56</b>	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. PLACE OF BIRTH (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Howard M. Barkley</b>				14. MOTHER'S NAME <b>Samie Williams</b>			
15. WAS DECEASED IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Helen Barkley Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>						PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus 5 yrs Inactive tuberculosis-3 yrs.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John Kehoe, M.D. Riverdale M.D.				22. DATE SIGNED <b>11-2-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>11-6-67</b>		23c. LOCATION (City or town) (County) (State) <b>Baltimore Md</b>			
24. FUNERAL DIRECTOR <b>Eloyo Wilson 1000 Brantley Ave</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15789

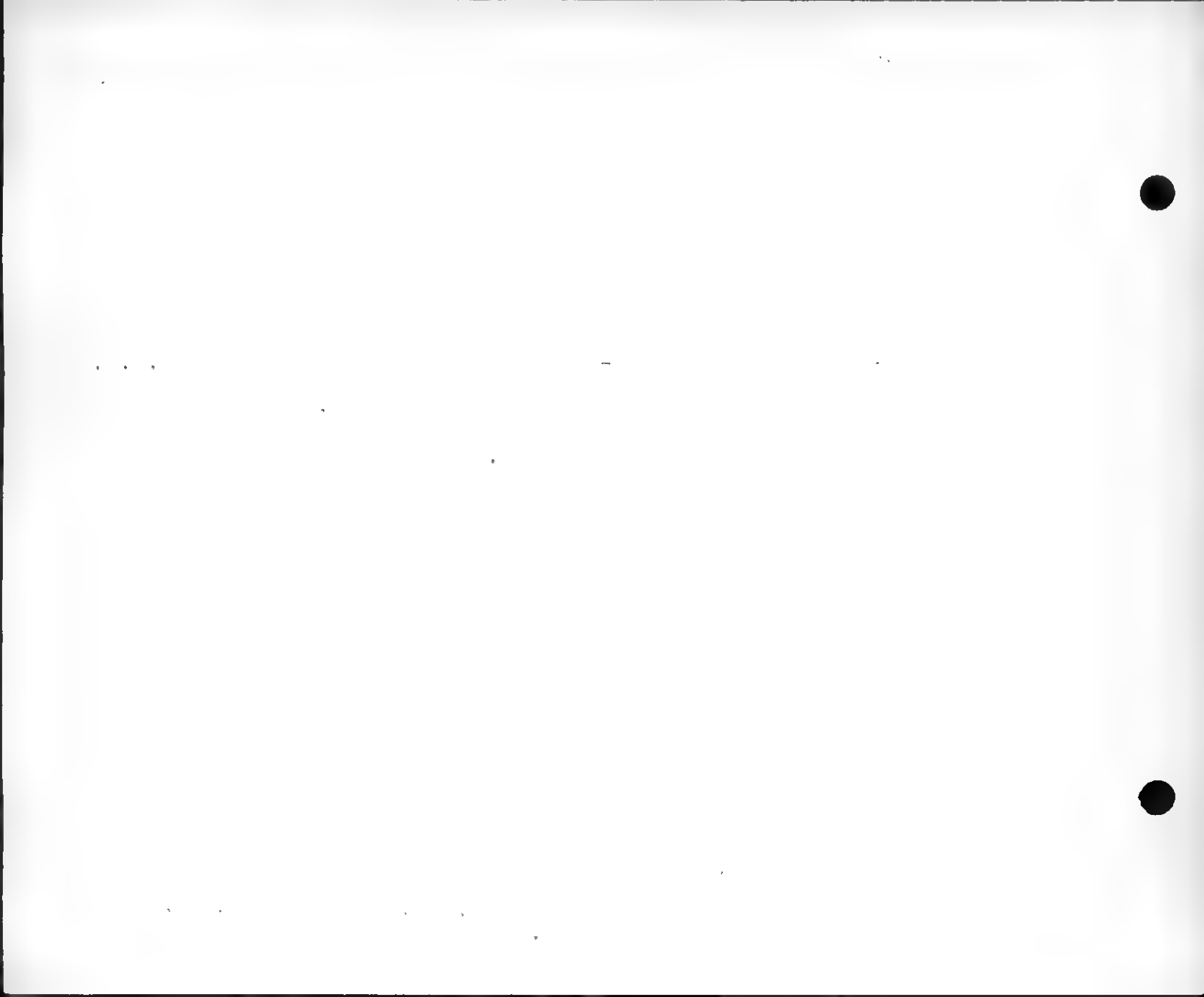
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15780

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. STREET ADDRESS <b>5024 55th Avenue</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Paul Douglas Barnes</b>		4. DATE OF DEATH Month Day Year <b>11 5 19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-67</b>
9. AGE (In years lost birthday) yrs <b>3</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>3 0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David D. Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Barbara G. Adams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>-</b>	
17. INFORMANT <b>Mr. David D. Barnes (above address)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Meningococcemia and Adrenal hemorrhage</b> // DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i> M.D. EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		22. DATE SIGNED <b>11-6-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/7/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Valley's Funeral Home Inc.</b>		25. RECEIVED BY REGISTRAR DATE <b>NOV 8 1967</b>	
ADDRESS <b>Mt. Rainier Maryland</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 2 and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15790

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15781

1 PLACE OF DEATH a COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>5600 Emerson Street</b>	
3 NAME OF (Type or print) <b>Annie Laura Bassette</b>		4 DATE OF DEATH Month <b>11</b> Day <b>5</b> Year <b>19 67</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-25-29</b>
9. AGE (In years last birthday) yrs. <b>38</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Texas 25, 1</b>		12. CITIZEN OF WHAT COUNTRY <b>U S. A.</b>	
13. FATHER'S NAME <b>Sam Shrum</b>		14. MOTHER'S MAIDEN NAME <b>Laura E. Beall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Philip Bassette</b>		Address <b>Same as #2 (husband)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral pneumonitis</b> DUE TO (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe M.D., Riverdale, Maryland</b>		22. DATE SIGNED <b>11-6-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL <b>Burial (Spec. 1)</b>		23b. DATE THEREOF <b>11/8/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, P.G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 9 1967</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

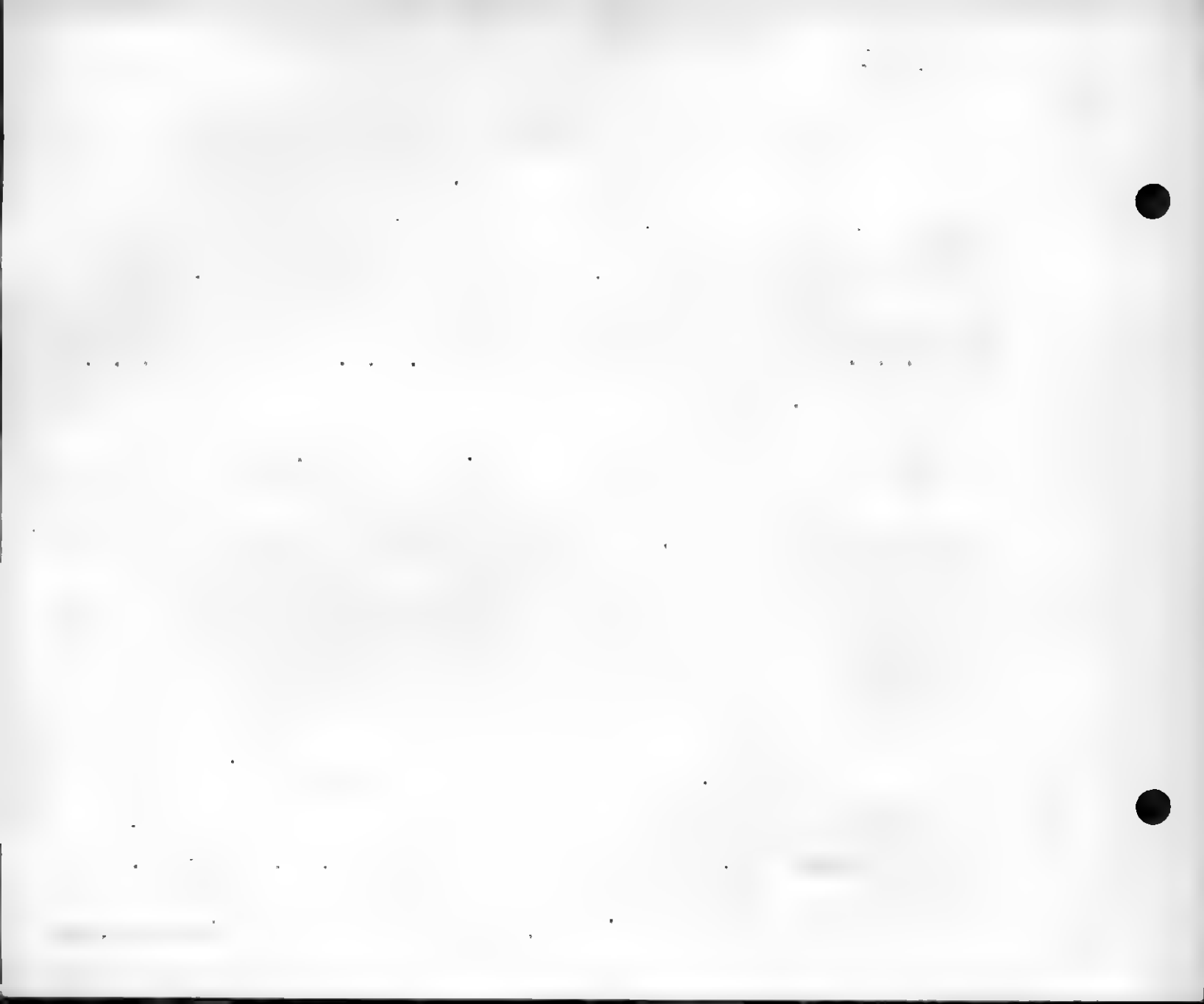
15791

CERTIFICATE OF DEATH

15782

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b> d. STREET ADDRESS <b>3409 Otis Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Paul J. Beckert</b>		4. DATE OF DEATH Month Day Year <b>Nov. 26 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/18/ 1907</b>
9. AGE (in years last birthday) <b>60</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>G.A.O.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Wash., D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert W. Beckert</b>		14. MOTHER'S MAIDEN NAME <b>Mary Krug</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Katherine G. Beckert (above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe Arteriosclerotic Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) ( <del>was not</del> ) attended the deceased from <b>Nov. 26, 1967</b> , to <b>Nov. 26, 1967</b> , that (I) ( <del>was not</del> ) last saw the deceased alive on <b>Nov. 26, 1967</b> , and that death occurred at <b>12:15 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Benjamin S. Miller</b>		22b. DATE SIGNED <b>Nov. 27, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Benjamin S. Miller</b>		22d. ADDRESS <b>3824 34th St., Mt. Rainier, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/29/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Wash., D.C.</b>
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25. REC'D BY REGISTRAR <b>DEC 4 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15792

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15783

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>District Of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>				47-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>1432 R Street, N. W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Roosevelt Belton</b>				4. DATE OF DEATH Month Day Year <b>11 1 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 April 1937</b>	9. AGE (In years last birthday) <b>30</b> yrs	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Caleman Belton</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Witherspoon</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>Vivian Belton</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Laceration of brain</b> DUE TO <b>Trauma - auto accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Passenger in car involved in a collision.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>11-1- 19 67 4:45pm</b>		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>US Rt. 1, 1 1/2 mile south of Laurel, Maryland</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>11-2-67</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>11-1-67</b>		23b. DATE THEREOF <b>Church</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church</b>		23d. LOCATION (City or Town) (County) (State) <b>S.C.</b>	
24. FUNERAL DIRECTOR <b>John D. Water</b>		ADDRESS <b>498-3435-14-5th St. Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>NOV 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15793

CERTIFICATE OF DEATH

15784

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>15 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5814 64th Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>L.</b> Last <b>Boarman</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>18</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1915</b>
9. AGE (In years last birthday) <b>52 yrs</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min <b>10</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>Howard Co., Md.</b>		13. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
14. FATHER'S NAME <b>Thomas Phillips</b>		15. MOTHER'S MAIDEN NAME <b>Nora Runkles</b>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>220 09 4513</b>	
18. INFORMANT <b>Harry E. Boarman Same as #2 (husband)</b>		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>1992</b> IMMEDIATE CAUSE (a) <b>COARCINOMATOSIS</b> DUE TO (b) <b>Primary lesion undetermined</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>About 7 to 10 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>11-18-67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-15-67</b> to <b>11-18-67</b> , that (I) (we) last saw the deceased alive on <b>11-16-67</b> , and that death occurred at <b>6:40 AM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>David S. Clayman</b>		22b. DATE SIGNED <b>11/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>David S. Clayman, M. D.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/21/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Western</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 22 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. L. Jones</b>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

15794

15785

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c LENGTH OF STAY in 1b <u>3 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyattsville Nursing Home</u>		d STREET ADDRESS <u>3516 Longfellow St.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Dr. Edward John Boe</u>		4 DATE OF DEATH Month Day Year <u>Nov. 11 1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-27-84</u>
9 AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Minneapolis, Minn.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Louis Boe</u>		14 MOTHER'S MAIDEN NAME <u>Mary Ryberg</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-38-3420</u>	
17. INFORMANT <u>Nursing Home Records-same as above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Myocardial Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <u>Generalized Arteriosclerosis</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>67</u> to <u>11 Nov.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11 Nov.</u> 19 <u>67</u> , and that death occurred at <u>12:30 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Wm. A. Wimsatt</u> M.D.		22b. DATE SIGNED <u>11 Nov. 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. A. Wimsatt</u>		22d. ADDRESS <u>3415 Hamilton Street</u> <u>Hyattsville Md.</u>	
23a. BURIAL OR CREMATION (Remove as applicable) <u>11/14/67</u>	23b. DATE THEREOF <u>11/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR <u>The S. H. Hines Co.</u> <u>Washington, D. C. 20009</u>		25a. REC'D BY REGISTRAR <u>NOV 14 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15786

15795

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-105. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN TB <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>612 Addison Road</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>Mae</b> Middle <b>Eliz.</b> Last <b>Boswell</b>		4. DATE OF DEATH Month <b>11</b> Day <b>1</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>20 March 1890</b>
9 AGE (In years last birthday) <b>77</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13 FATHER'S NAME <b>William E. Loveless</b>	
14. MOTHER'S MAIDEN NAME <b>Alice Grimes</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) <b>No</b> (If yes give war or dates of service) <b>--</b>	
16 SOCIAL SECURITY NO. <b>579-05-1380</b>		17 INFORMANT <b>Harry G. Boswell-Same as Item #2.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Hypertensive cardio vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>DUE TO</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>over 10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CONTRIBUTING TO DEATH</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>11-2-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/4/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Upper Marlboro, Md.</b>
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 14 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

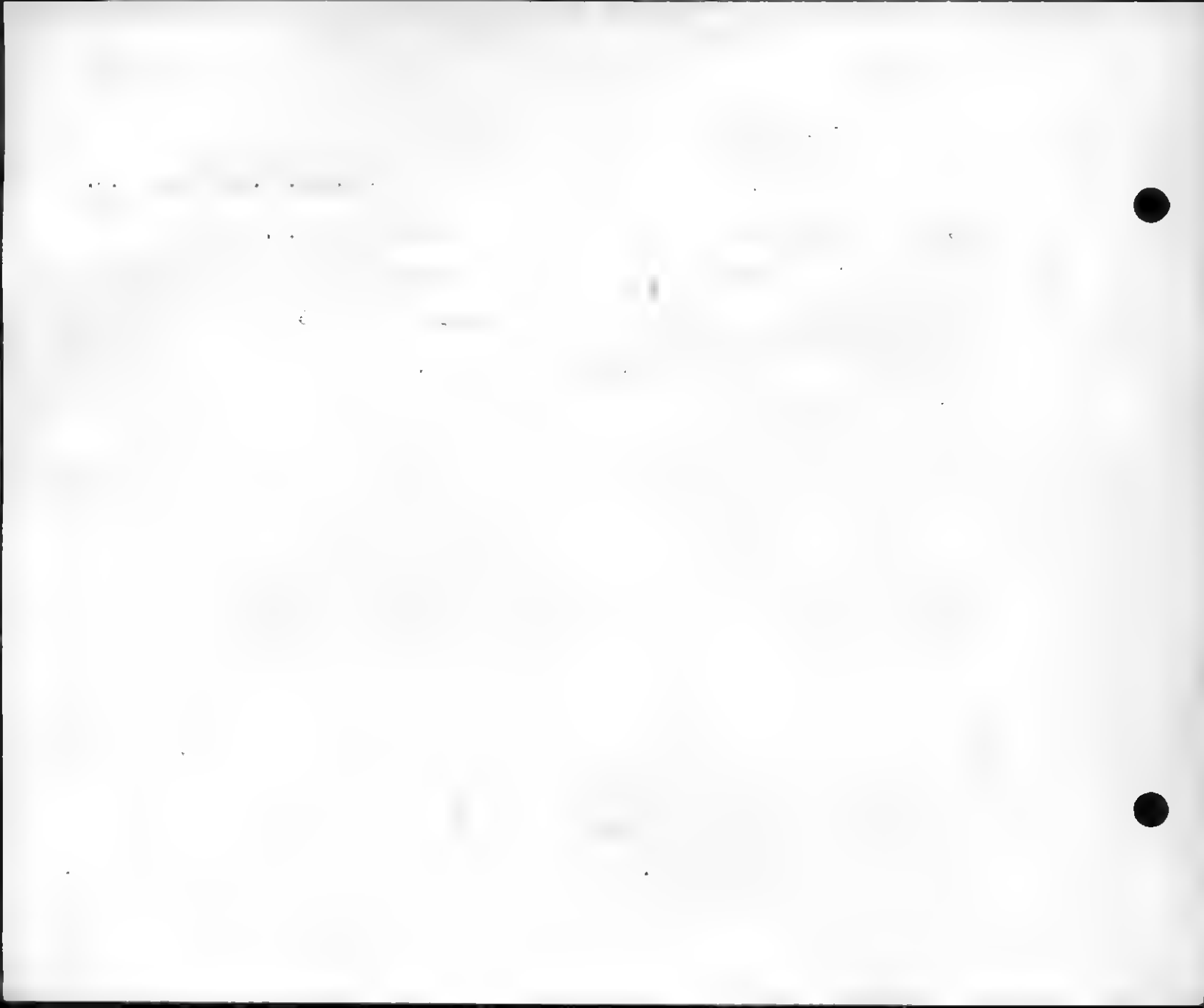
15798

CERTIFICATE OF DEATH

15787

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>			c. LENGTH OF STAY IN It <b>6 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>810 5th St., N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maurice</b> Middle <b>H.</b> Last <b>Bowers</b>				4. DATE OF DEATH Month <b>11</b> - Day <b>27</b> - Year <b>1967</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10/31/02</b>		9. AGE (In years last birthday) <b>65</b> yrs.	10. IF UNDER 1 YEAR Months <b>11</b> Days <b>27</b> Hours <b>00</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Raleigh Bowers</b>				14. MOTHER'S MAIDEN NAME <b>Nell McCulery</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>decedent</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-intestinal hemorrhage</b> 277 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) <b>Polycythemia vera</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>  <b>6 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic alcoholism; peripheral neuropathy; chronic brain syndrome</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>4/19/</b> , 19 <b>67</b> , to <b>11/27/</b> , 19 <b>67</b> , that <del>he</del> (we) last saw the deceased alive on <b>11/27/1967</b> , and that death occurred at <b>10:55 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Moe Weiss</i>				22b. DATE SIGNED <b>11/27/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-1-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co Md</b>	
24. FUNERAL DIRECTOR <i>Robert A Mattingly</i>				25a. REC'D BY REGISTRAR <b>NOV 20 1967</b>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>	





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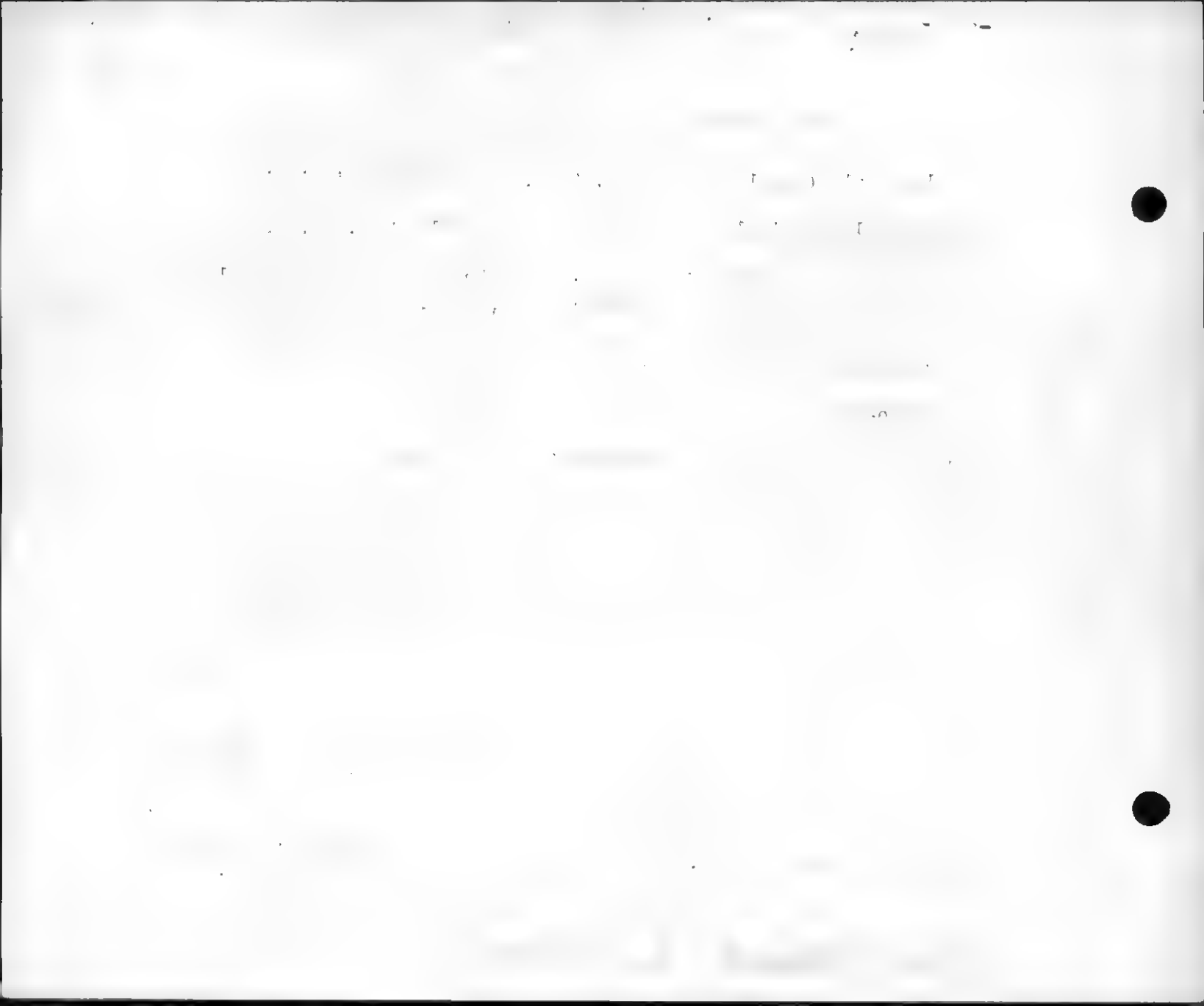


15797 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15788

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Washington, D. C.</b> b. COUNTY <input checked="" type="checkbox"/>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c LENGTH OF STAY IN 1b <b>5 mos., 3 wks.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>1617 T St., S. E.</b>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Dorothy L. Bowie</b>		4. DATE OF DEATH Month Day Year <b>11 7 19 67</b>	
5. SEX <b>F</b>	6 COLOR OR RACE <b>N</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>unknown</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/30/1913</b>
9. AGE (In years last birthday) <b>54</b> yrs		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife?</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-03-1613</b>	
17 INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO <b>Recurrent cerebrovascular accidents with encephalomalacia</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>  <b>years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>(he)</del> (this hospital) attended the deceased from <b>5/1/77</b> , 19 <b>67</b> , to <b>11/7, 1967</b> , that <del>(he)</del> (we) last saw the deceased alive on <b>11/7/19 67</b> , and that death occurred at <b>2:40 AM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>11/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11-11-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY MEMORIAL PARK</b>	23d. LOCATION (City or town) (County) (State) <b>PRINCE GEORGE'S, MARYLAND</b>
24. FUNERAL DIRECTOR <b>John T. Phelan</b>		25a REC'D BY REGISTRAR DATE <b>NOV 13 1967</b>	
ADDRESS <b>30 N-14 ST NE</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

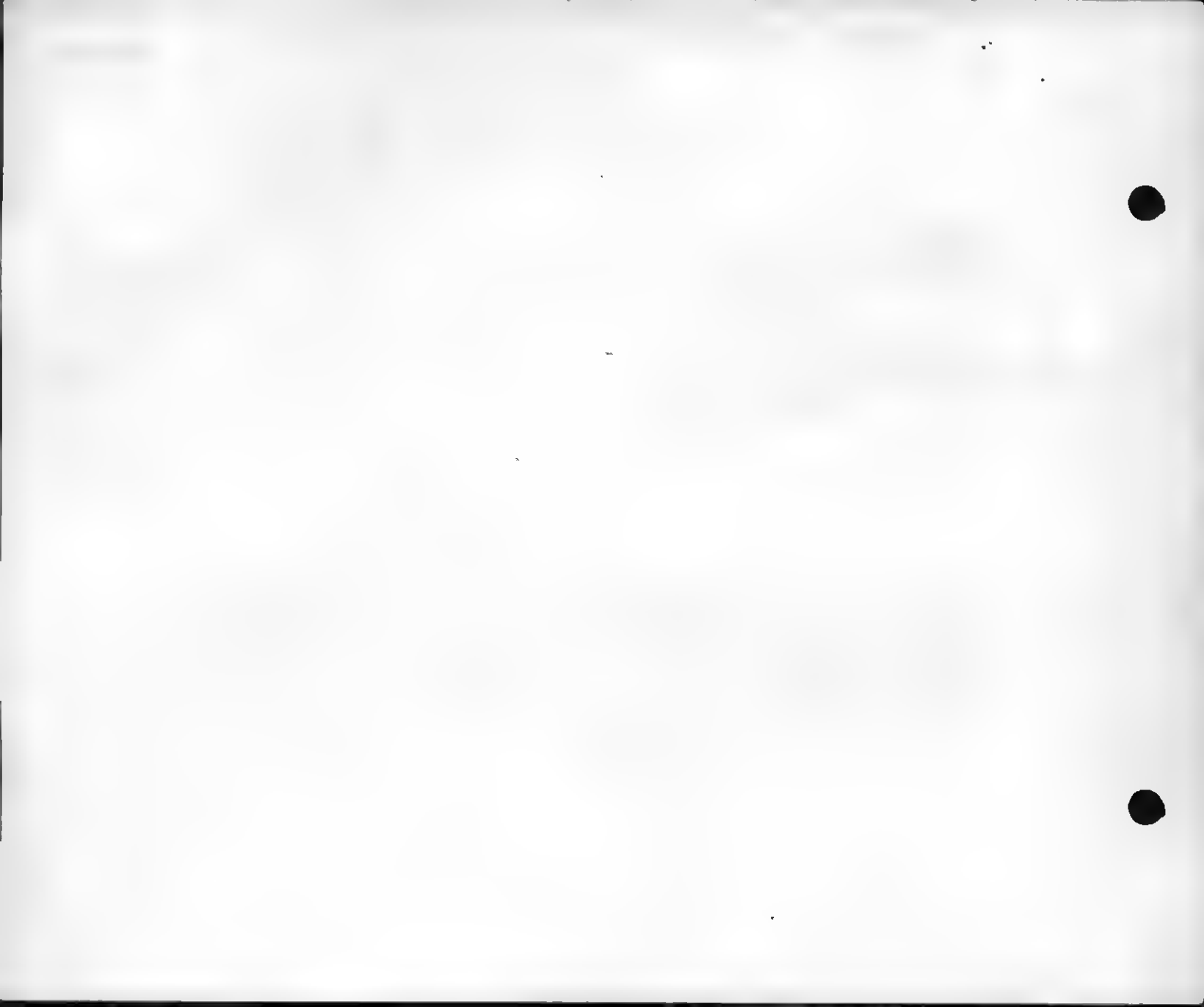
CERTIFICATE OF DEATH

15798

15789

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Petersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Nursing &amp; Rehab Center</u>		e. STREET ADDRESS <u>815 7<sup>th</sup> Ave South</u>	
3 NAME OF DECEASED (Type or print) First <u>Winfield</u> Middle <u>S.</u> Last <u>Boyer</u>		4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-9-1892</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd - U.S. Govt</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Msgr Betty C. Roberts - 7733 Waltham Ave</u>		Address <u>Qot 202</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cancer of Stomach</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-16</u> , 19 <u>67</u> , to <u>11-23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-23</u> , 19 <u>67</u> , and that death occurred at <u>2</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John F. Shay</u>		22b. DATE SIGNED <u>11-23-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John F. Shay</u>		22d. ADDRESS <u>5509-Old Silver Hill Rd SE, Suitland Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 27-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Simmons Bros</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1967</u>	
ADDRESS <u>Simmons Bros. 1661-Good Hope Rd SE Wash DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charmela Jones</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 20a-20f-film #395		MARYLAND STATE DEPARTMENT OF HEALTH	
12-12-67 mt		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
15793		15790	
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY in 1b <b>8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if inst tut on Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b> d. STREET ADDRESS <b>8 K Plateau Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>DAVID</b> Last <b>Breen</b>		4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/29/17</b>
9. AGE (In years lost birthday) <b>49</b> yrs		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>	11. IF UNDER 24 HRS Months <b></b> Days <b></b> Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>HERBERT A. BREEN</b>	
14. MOTHER'S MAIDEN NAME <b>AMANDA ELLIS</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> <b>W.W. II</b>	
16. SOCIAL SECURITY NO. <b>154 07 0731</b>		17. INFORMANT <b>MRS ELINOR J. BREEN</b> Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>702.7 RESPIRATORY FAILURE</b> DUE TO (b) <b>HYPOTENSIVE PNEUMONIA</b> DUE TO (c) <b>FRACTURE, RIGHT HIP</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>① Parkinsonism ② Severe Malnutrition</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Patient fell in nursing home leaving bed</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11</b> 10 <b>1967</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Nursing home</b>	20f. (City or town) (County) (State) <b>Greenbelt Pr. Geo. Md</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 10</b> , 1967, to <b>Nov. 18</b> , 1967, that (I) (we) last saw the deceased alive on <b>Nov. 18</b> , 1967, and that death occurred at <b>3:55AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Arnold G. Brody</b>		22b. DATE SIGNED <b>11/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M.D.</b>		22d. ADDRESS <b>Prince George's General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Nov 21, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEM.</b>	23d. LOCATION (City or town) (County) (State) <b>COLMAR MANOR, Md.</b>
24. FUNERAL DIRECTOR <b>W.W. Chambers Co</b>		25. REC'D BY REGISTRAR <b>NOV 22 1967</b>	
ADDRESS <b>Riverdale, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15800

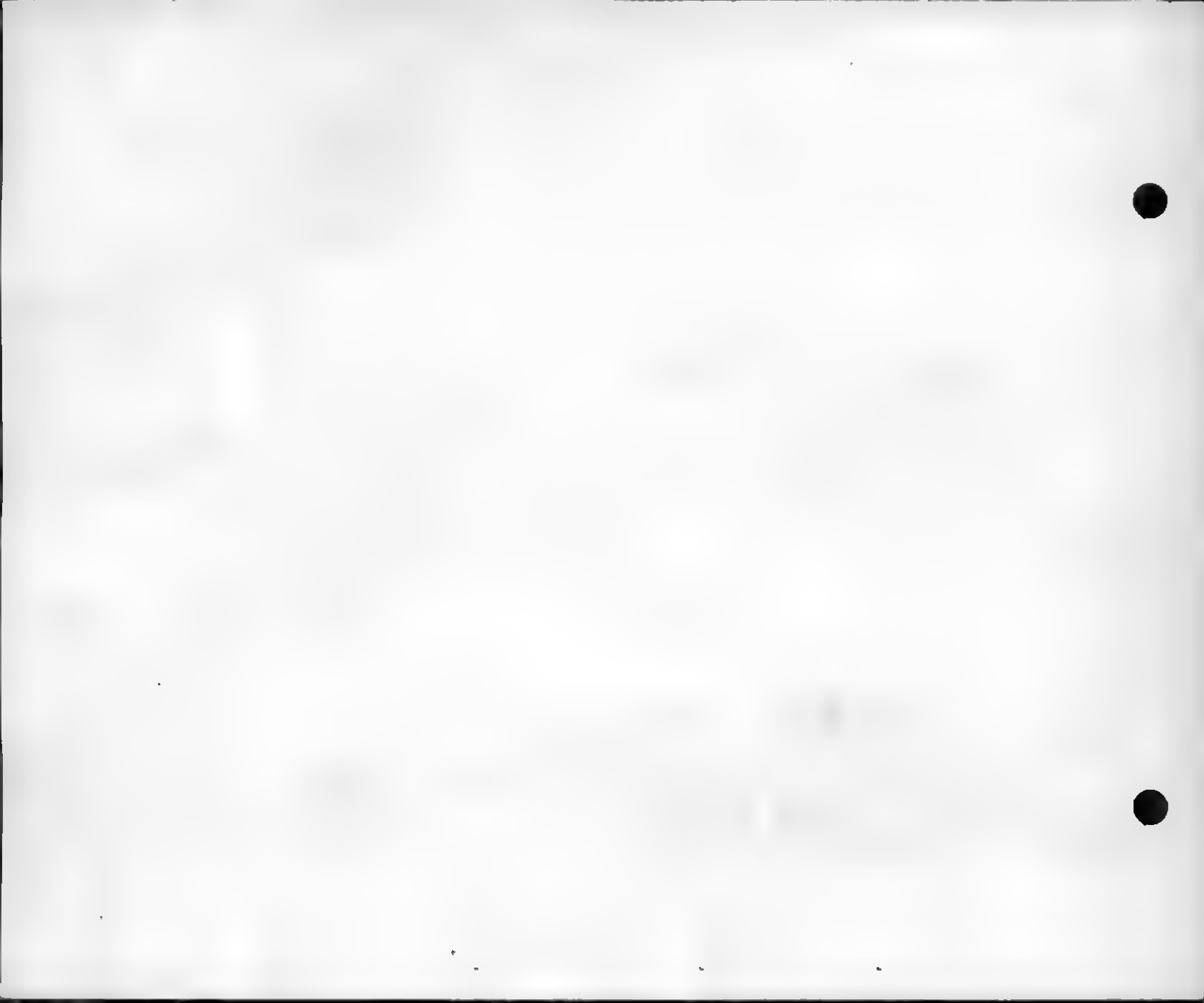
**CERTIFICATE OF DEATH**

15791

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Hyattsville Md.</u>		c. LENGTH OF STAY in 1b <u>6 WKS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyattsville Nursing Home 6500 Riggs Rd.</u>		d. STREET ADDRESS <u>12924 Dean Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Willis</u> Last <u>Bridges</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>88</u> <u>12-13-1888</u>
9. AGE (In years last birthday) <u>78</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookbinder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Nashville Tenne</u>		12. C. TIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Bridges</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-40-5796</u>	
17. INFORMANT <u>Mrs. James Hart Wheaton</u>		Address <u>12924 Dean Road</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>year</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept.</u> , 1967, to <u>11-25</u> , 1967, that (I) (we) last saw the deceased alive on <u>11-23</u> , 1967, and that death occurred at <u>11 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Donald C. Edgren</u> M.D.		22b. DATE SIGNED <u>11-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DONALD C. EDGREN</u>		22d. ADDRESS <u>3500 East-West Highway Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov 27, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>8434 Georgia Ave. Silver Spring, Md.</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 28 1967</u>	





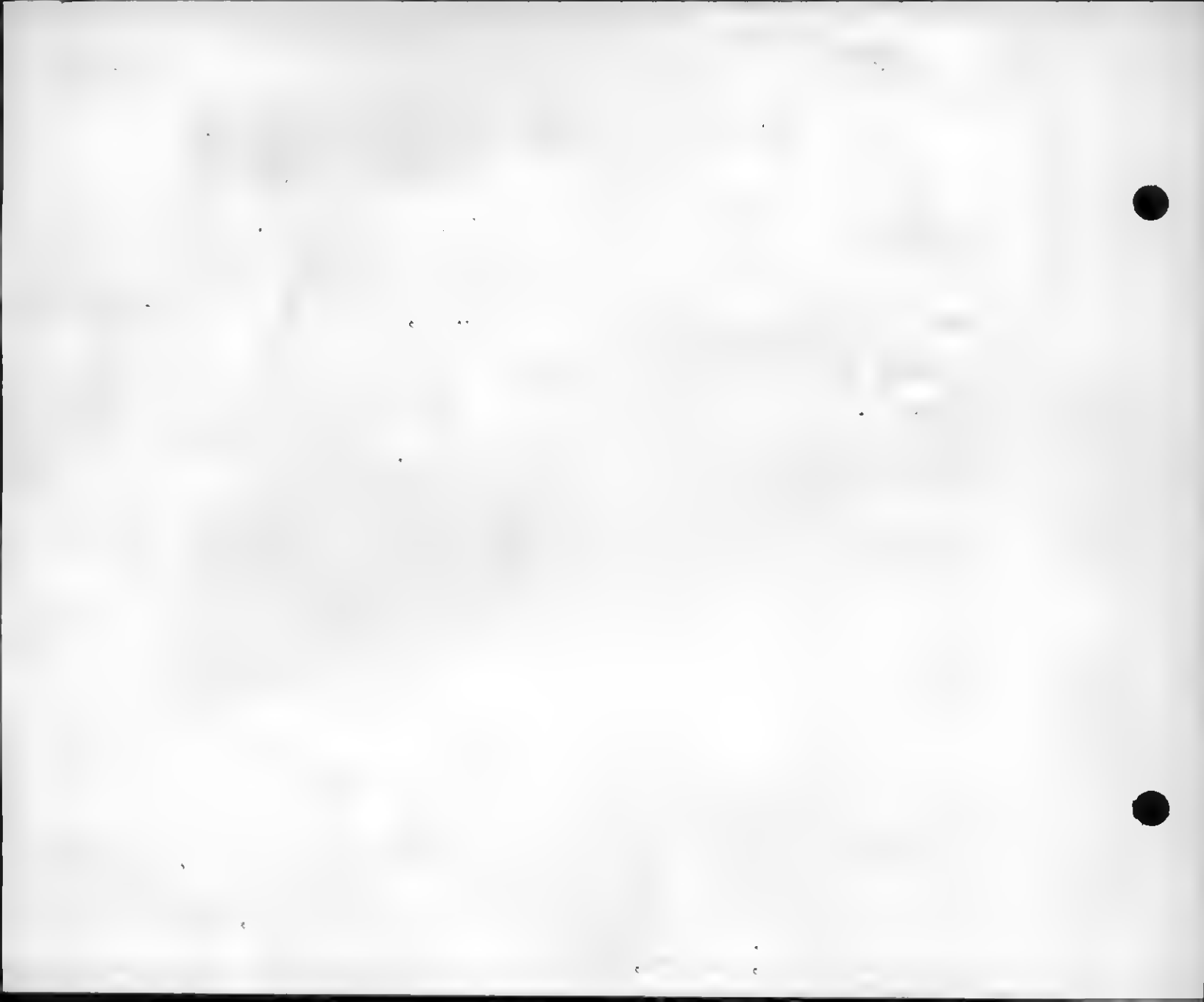
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORESTVILLE</b>				c. LENGTH OF STAY IN b. <b>DISTRICT HEIGHTS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>REGENCY NURSING CENTER</b>				d. STREET ADDRESS <b>7821 GATEWOOD BLVD.</b>			
3 NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>P.</b> Last <b>BROWN</b>				4 DATE OF DEATH Month <b>Nov</b> Day <b>14</b> Year <b>1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1878 DEC. 30, 1879</b>		9. AGE (In years last birthday) <b>88</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>		11. BIRTHPLACE (County & State, or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES W. BROWN</b>				14. MOTHER'S MAIDEN NAME <b>SARAH MALCOLM</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MARGARET B. TRUESDELL</b> Address <b>SAME AS # 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO (b) <b>Cerebral Vascular Accident</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , 19 to <b>Nov. 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 13, 1967</b> , and that death occurred at <b>6:15 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>W.B. Sheer</b>				22b. DATE SIGNED <b>11-14-67</b>		22c. PHYSICIAN'S NAME (Type) <b>WALTER B. SHEER</b>	
22d. ADDRESS <b>6400 MARLBORO PIKE S.E. WASH. D.C.</b>				22e. REC'D BY REGISTRAR <b>Charles Judge</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>11/17/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>		23d. LOCATION (City or Town) (County) (State) <b>SUITLAND, PRINCE GEORGES, MD</b>	
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>				25. DATE <b>NOV 20 1967</b>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

15802

15784

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton, Maryland</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Temple Hills</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Garden's Health Care Center</u>				d. STREET ADDRESS <u>5114 Fisher Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>M</u> Last <u>Bucheler</u>				4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-8-86</u>	
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. BIRTHPLACE (County & State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus. of Engraving (Exam)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (County & State or foreign country) <u>Wash. D.C.</u>	
13. FATHER'S NAME <u>James Summers</u>				14. MOTHER'S MAIDEN NAME <u>Alice Posey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-09-24499</u>		17. INFORMANT <u>M. Hart, RN</u>		Address <u>5905 Fisher Rd. Oxon Hill, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>							
DUE TO (b) <u>ARTERIO SCLEROTIC HEART DISEASE 3 months</u>							
DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL VASCULAR DISEASE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-21</u> , 19 <u>67</u> , to <u>11-28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-28-67</u> , and that death occurred at <u>8</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Alfred R. Lavin M.D.</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R LAVIN M.D.</u>				22d. ADDRESS <u>CLINTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>				ADDRESS <u>Washington</u>		25a. REC'D BY REGISTRAR <u>D. DEC 4 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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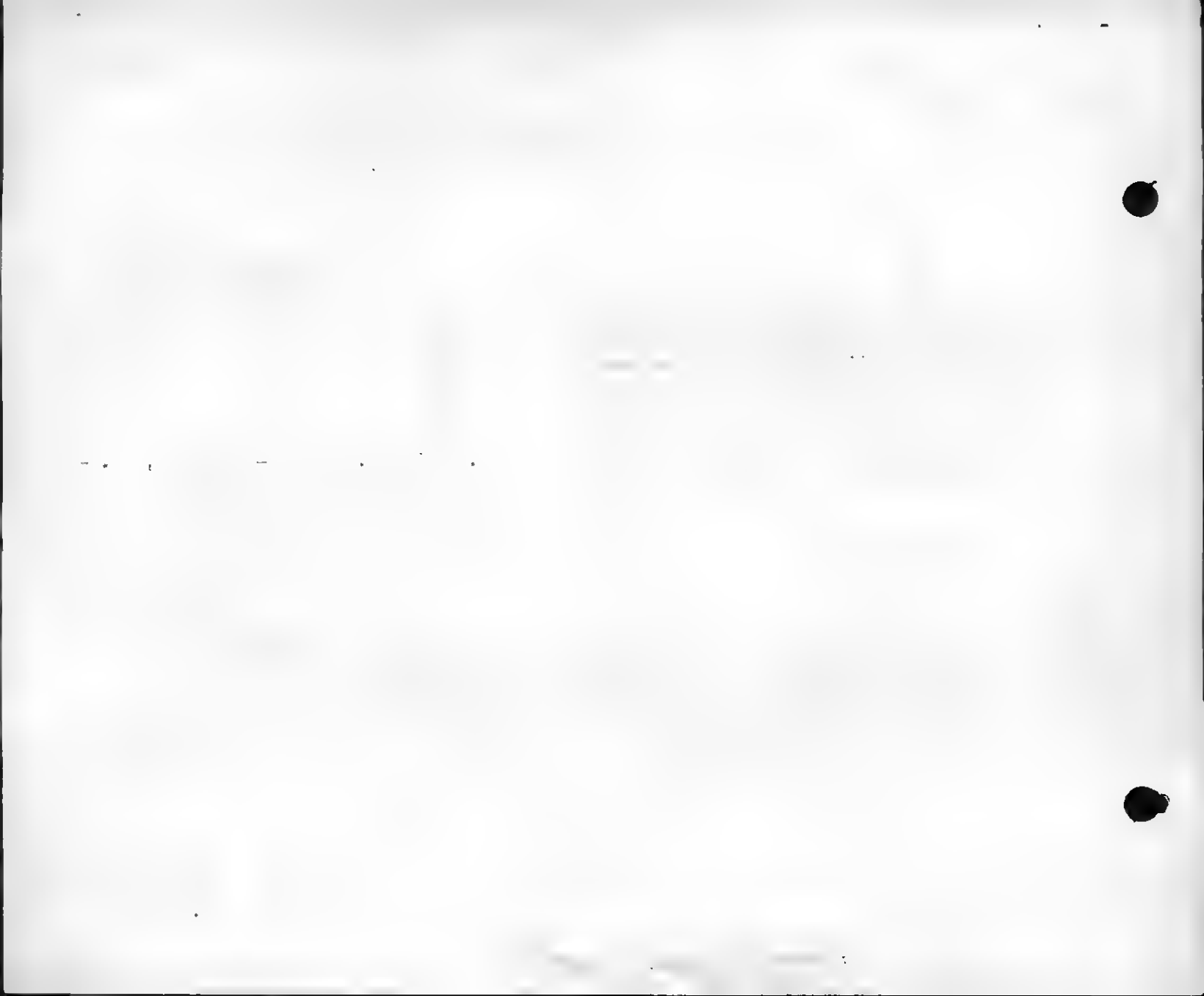
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15803

CERTIFICATE OF DEATH

15795

1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Maryland		c LENGTH OF STAY IN 1b 1 month	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood, Maryland
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bryant-Leland Memorial Hospital		d STREET ADDRESS 4230 41st Avenue	
3 NAME OF DECEASED (Type or print) First Middle Last Ora M. Bullock		4 DATE OF DEATH Month Day Year Nov. 17 1967	
5 SEX Fe	6 COLOR OR RACE Colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-6-01
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY Government	9 AGE (In years last birthday) yrs. 66
11 BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME George W. Bullock		14 MOTHER'S MAIDEN NAME Mary Simonett	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16 SOCIAL SECURITY NO. 213-12-1700	
17 INFORMANT Mr. Philip C. Bullock-Arlington, Va. - Son		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 332x DUE TO Cerebral Thrombosis (b) Gangrene of leg. (c) DUE TO General arterio-sclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 mo 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 15, 1967 to Nov 17, 1967, that (I) (we) last saw the deceased alive on Nov 17, 1967, and that death occurred at 12:45 PM, from causes and on the date stated above			
22a SIGNATURE L W MALIN M.D.		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) L W MALIN, MD		22d ADDRESS Riverdale 210	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11/21/67	23c NAME OF CEMETERY OR CREMATORY Carver Memorial Park	23d LOCATION (City or Town) (County) (State) Laurel, Md.
24 FUNERAL DIRECTOR John T. Plinio Co. 3015-12 08 YRG		25a REC'D BY REGISTRAR DATE NOV 24 1967	
		25b REGISTRAR'S SIGNATURE Michael Judge	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

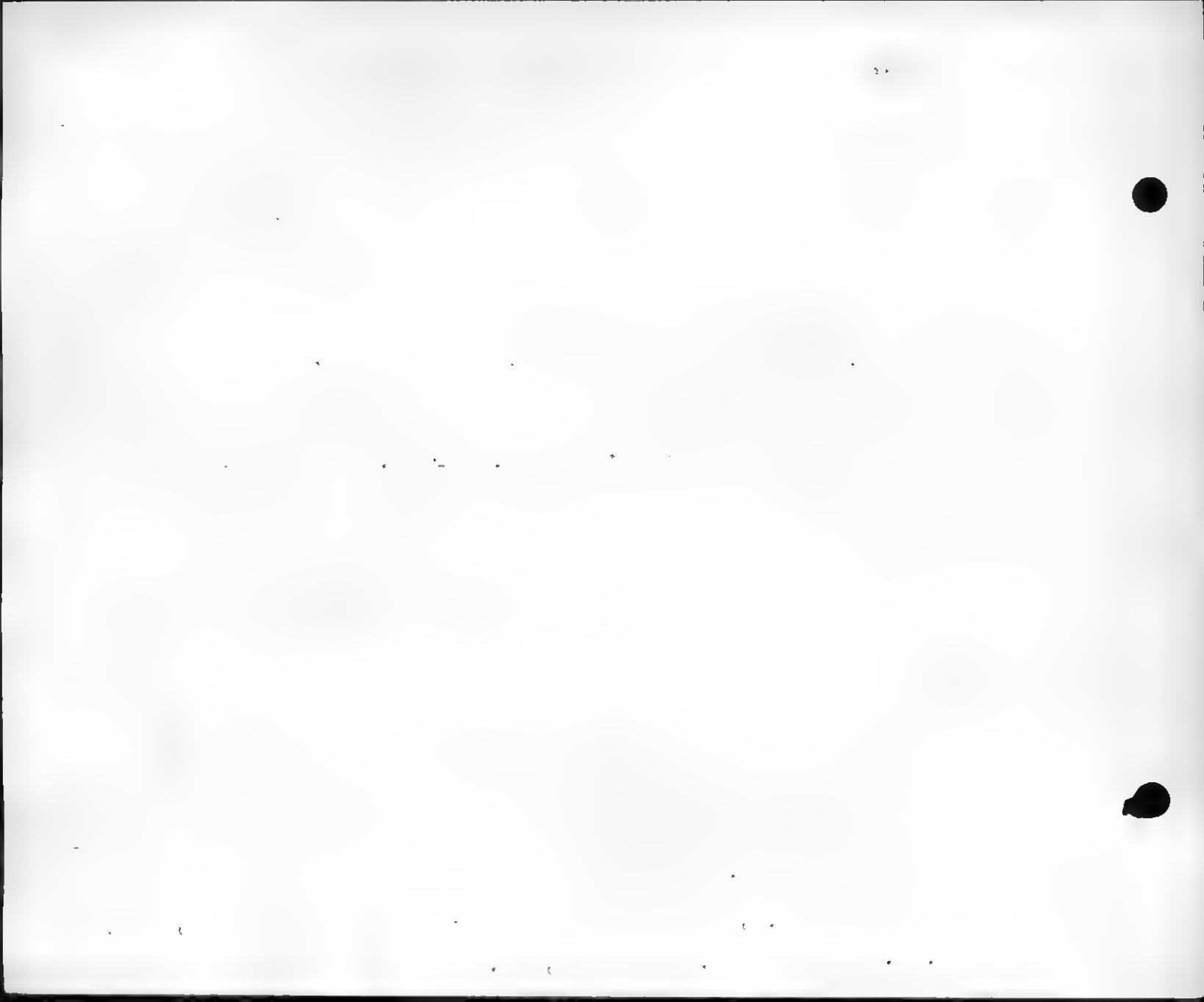
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15796

5804

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>College Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>4915 Erie Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Dorothea Katherine Burd</b>				4 DATE OF DEATH Month Day Year <b>11 5 19 67</b>			
5 SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7-27-13</b>	9 AGE (In years last birthday) <b>54</b> YRS	F UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE, CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEWART MOTOR CO</b>		11 BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S</b>	
13. FATHER'S NAME <b>John Copp</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Schaeffer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>None</b>		17 INFORMANT <b>Mr. Harry G. Burd, Same as #2</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> <b>51.5X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>months</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22 DATE SIGNED <b>11-6-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		Address (Street city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 8, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bladensburg, Maryland</b>	
24 FUNERAL DIRECTOR <b>W. W. CHAMBERS CO. Riverdale, Md.</b>				25a. REC'D BY REG. STRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
				DATE <b>NOV 9 1967</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BGP

1 (M)

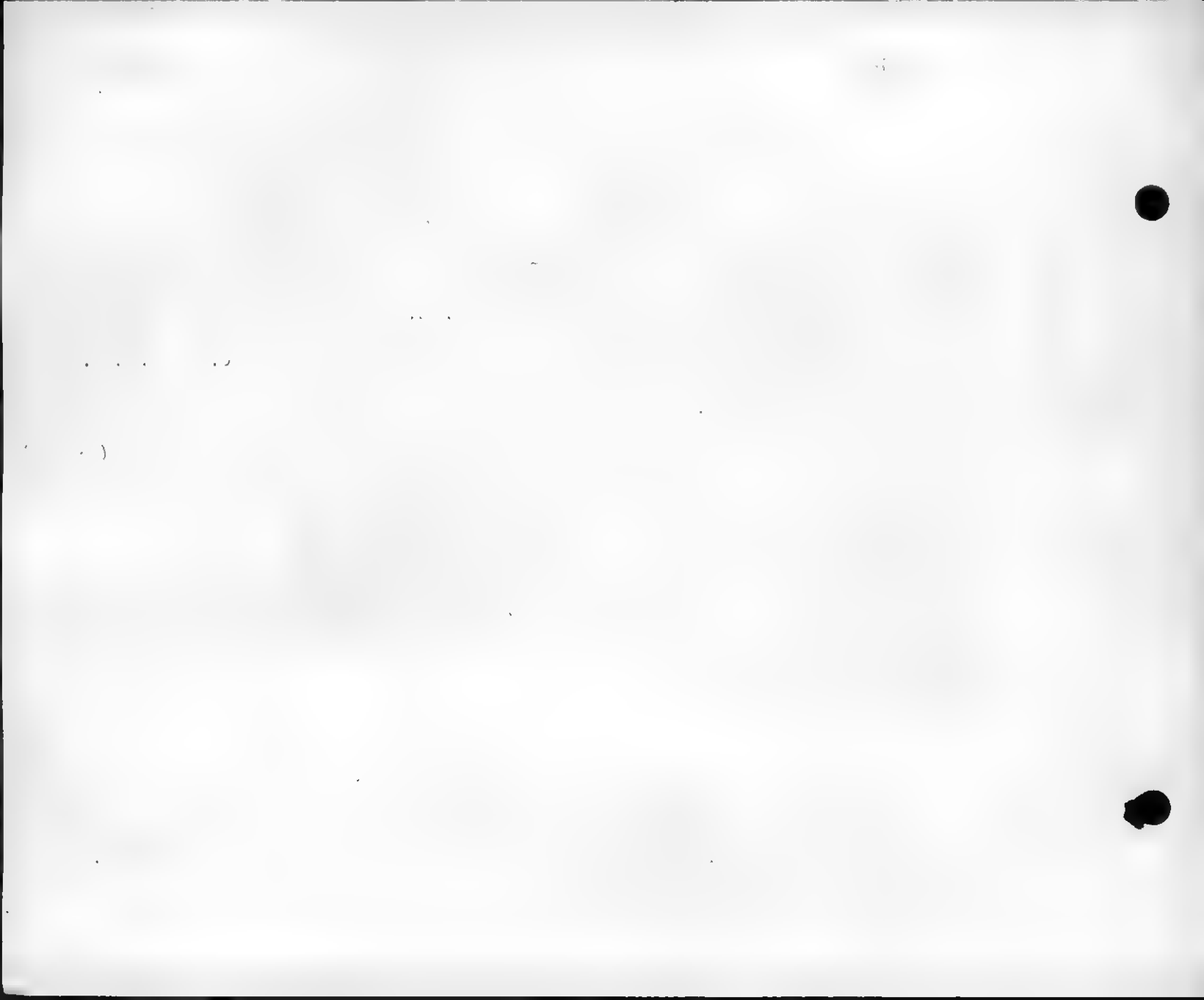
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15805

CERTIFICATE OF DEATH

15757

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>18 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>7548 Newberry Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Douglas</b> Middle <b>Christian</b> Last <b>Butler</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>19,</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 2, 1966</b>	
9. AGE (In years last birthday) <b>1</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b></b> Hours <b></b> Min. <b></b>		11. BIRTHPLACE (County & State or foreign country) <b>Prince George Co, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Linwood C. Butler Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Dinsmore</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Linwood C. Butler Jr. Same as #2 (father)</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>180X</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO (b) <b>Wilm's tumor of kidneys</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b></b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>10/13/66</b> , 19 <b>67</b> , to <b>Nov 19</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov 18</b> , 19 <b>67</b> , and that death occurred at <b>1:10 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Gordon W. Kelly</b>				22b. DATE SIGNED <b>11/20/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Gordon W. Kelly, M. D.</b>	
22d. ADDRESS <b>6124 41st Ave. Hyattsville, Md.</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/21/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Prince George Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15805

CERTIFICATE OF DEATH

15798

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY in 1b <b>15 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capitol Hights</b> d. STREET ADDRESS <b>630 61st Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E.</b> Last <b>Cain</b>		4 DATE OF DEATH Month <b>Nov.</b> Day <b>23</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/22/79</b> <del>XXXXXX</del>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>19</b> Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John J. Kefe</b>		14. MOTHER'S MAIDEN NAME <b>Margaret C. Faulkner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mary A. Seipp</b>		Address <b>Same As # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sub Dural Hematoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>(x)</del> (this hospital) attended the deceased from <b>Nov. 8,</b> 19 <b>67</b> , to <b>Nov. 23,</b> 19 <b>67</b> , that <del>(x)</del> (we) last saw the deceased alive on <b>Nov. 23,</b> 19 <b>67</b> , and that death occurred at <b>11:50 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Arnold G. Brody</i> M.D.		22b. DATE SIGNED <b>P.M.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M. D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/27/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm</b> <b>4308 Suitland Road, Suitland, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 30 1967</b> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1911

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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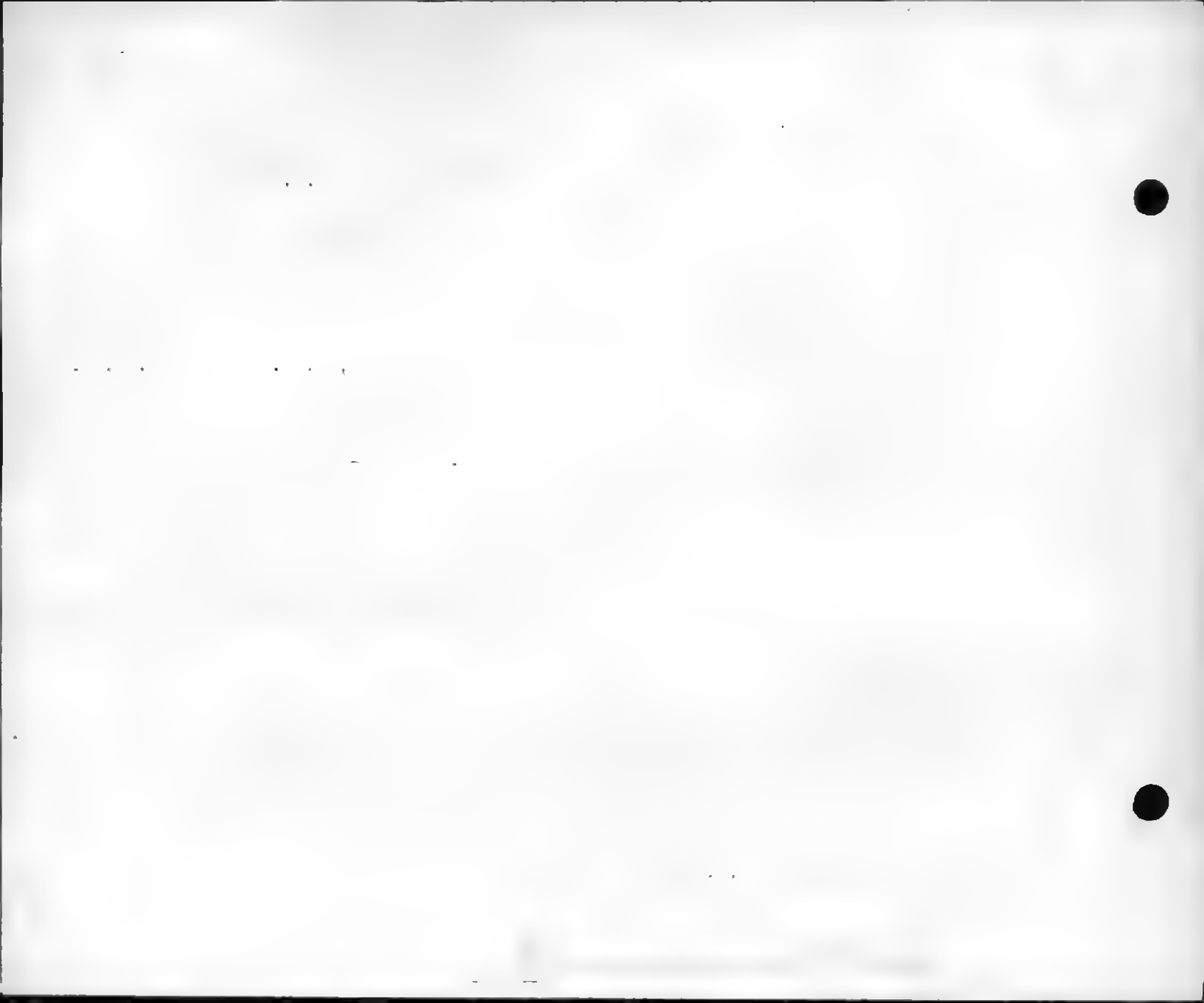
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15807

15789

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>1717 Franklin Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Fleada Gordon Cameron</b>				4 DATE OF DEATH Month Day Year <b>11 3 19 67</b>			
5 SEX <b>female</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1-13-19</b>	9 AGE (In years last birthday) yrs. <b>48</b>	10 UNDER 1 YEAR Months Days Hours Min.		11 UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11 BIRTHPLACE (State or foreign country) <b>York City, S. C.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>Henry Gordon</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Steele</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>None No</b>		16 SOCIAL SECURITY NO		17 INFORMANT Address <b>John R. Cameron-1717 Franklin Street, NE Husband</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>LACERATION OF DBA TRAUMA AUTO ACCIDENT Man.</b>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>passenger in car involved in collision</b>					
20c. TIME OF DEATH Month Day Year Hour am pm <b>12:20pm 11-3 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 1 at Pappas Road, Prince George's, Md.</b>		20f. (City or town) (County) (State) <b>Prince George's, Md.</b>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kenoe</b>		EXAMINER'S NAME (Type) <b>John Kenoe M.D., Riverdale, Maryland</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>11-4-67</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/9/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland P.G. Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>John T. Pappas Co. 3015 12th St NW</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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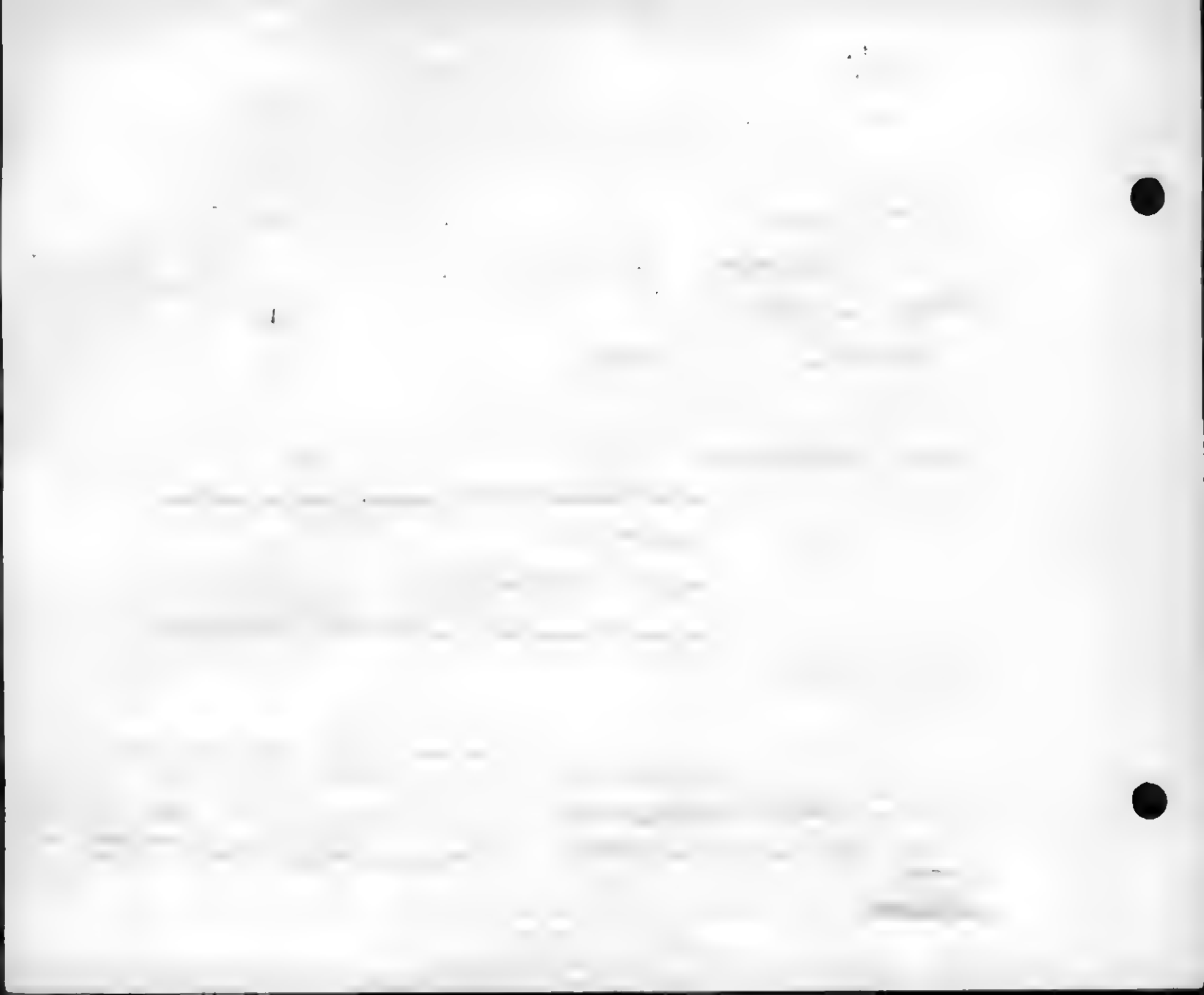
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15800

15808

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camp Springs</b>		c. LENGTH OF STAY IN TB <b>5 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FALLS CHURCH</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>M. Grow Hospital</b>				d. STREET ADDRESS <b>7107 NORWALK ST</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>William G. Campbell Jr</b>				4 DATE OF DEATH Month <b>Nov</b> Day <b>23</b> Year <b>1967</b>			
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>185422 25</b>	9 AGE (in years last birthday) <b>42</b> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NAVIGATOR</b>		10b KIND OF BUSINESS OR INDUSTRY <b>USAF</b>		11 BIRTHPLACE (County & State, or foreign country) <b>LAS VEGAS, NEW MEXICO</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>William C. Campbell Jr</b>				14 MOTHER'S MAIDEN NAME <b>SLEISTER, Jesse</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES 1942-1947</b>		16 SOCIAL SECURITY NO <b>454-26-6472</b>		17 INFORMANT <b>Nancy Campbell (wife)</b>		Address <b>7107 NORWALK ST</b>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UGI BLEEDING (upper gastric intestinal)</b> DUE TO <b>GASTRITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>WUPES NEPHRITIS</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>HYPERTENSION, CONGESTIVE HEART FAILURE</b>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (H) (this hospital) attended the deceased from <b>16th MAY, 1967</b> , to <b>23 Nov, 1967</b> , that (H) (we) last saw the deceased alive on <b>23 Nov 1967</b> , and that death occurred at <b>1220</b> M, from causes and on the date stated above.							
22a SIGNATURE <b>Michael S. Goldstein</b>				22b ADDRESS <b>Malcolm Grow Hosp.</b>		22c DATE SIGNED <b>Nov 23, 1967</b>	
22c PHYSICIAN'S NAME (Type) <b>Michael S. Goldstein</b>				22d ADDRESS <b>ANDREWS AFB WASHINGTON DC</b>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <b>11-28-67</b>		23c NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L.</b>		23d LOCATION (City or Town) (County) (State) <b>ARLINGTON, VA</b>	
24. FUNERAL DIRECTOR <b>FALLS CHURCH F. H.</b>				25a REC'D BY REGISTRAR <b>NOV 27 1967</b>		25b REGISTRAR'S SIGNATURE <b>OFFICIAL, JUDGE</b>	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

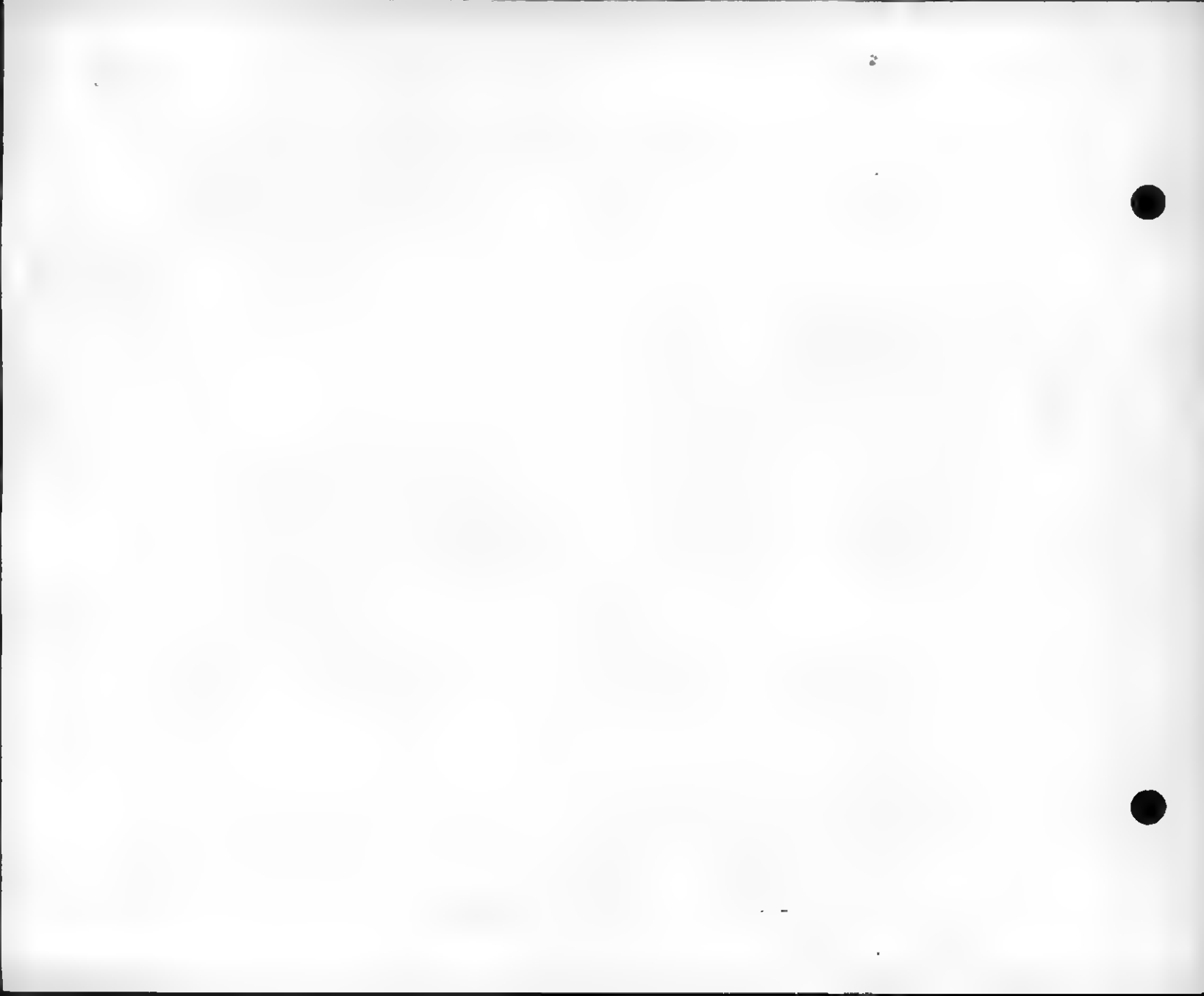
**CERTIFICATE OF DEATH**

15803

15801

<b>1 PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Andrews AFB</u> c. LENGTH OF STAY IN TB  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Andrews Air Force Hospital</u>		<b>2 USUAL RESIDENCE</b> (Where deceased lived if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P. G.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND, MARYLAND</u> d. STREET ADDRESS <u>4704 CHERYL LANE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3 NAME OF DECEASED</b> (Type or print) First <u>IDA</u> Middle <u>CAPANO</u> Last <u>CAPANO</u> <b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>5</u> Year <u>1967</u>		<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>MAY 10, 1899</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>68</u> yrs <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, read if retired) <u>HOUSEWIFE</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>PHILADELPHIA PA</u> <b>12. CITY, ZEN OF BIRTH COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>CHARLES JANNETTI</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>JOSEPHINE ?</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <b>16. SOCIAL SECURITY NO</b>  <b>17. INFORMANT</b> <u>CHARLES DE CESARIS</u> Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC C.V. DISEASE</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)  <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u>11-5</u> <b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Nat White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  <b>20f. (City or town) (County) (State)</b>  <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1961</u> , 19 <u>67</u> , to <u>11-5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-5</u> , 19 <u>67</u> , and that death occurred at <u>11-5</u> , 19 <u>67</u> , M, from causes and on the date stated above.	
<b>22a. SIGNATURE</b> <u>Benjamin S. Pearson</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>BENJAMIN S. PEARSON MD</u>		<b>22b. DATE SIGNED</b>  <b>22d. ADDRESS</b> <u>6106 OLD SILVER HILL ROAD</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>11-9-1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>4308 Cedar Hill Cemetery</u> <b>23d. LOCATION (City or Town) (County) (State)</b> <u>Suitland Maryland</u>	
<b>24. FUNERAL DIRECTOR</b> <u>Robert E. Wilhelm Funeral Home Suitland Md</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>NOV 10 1967</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

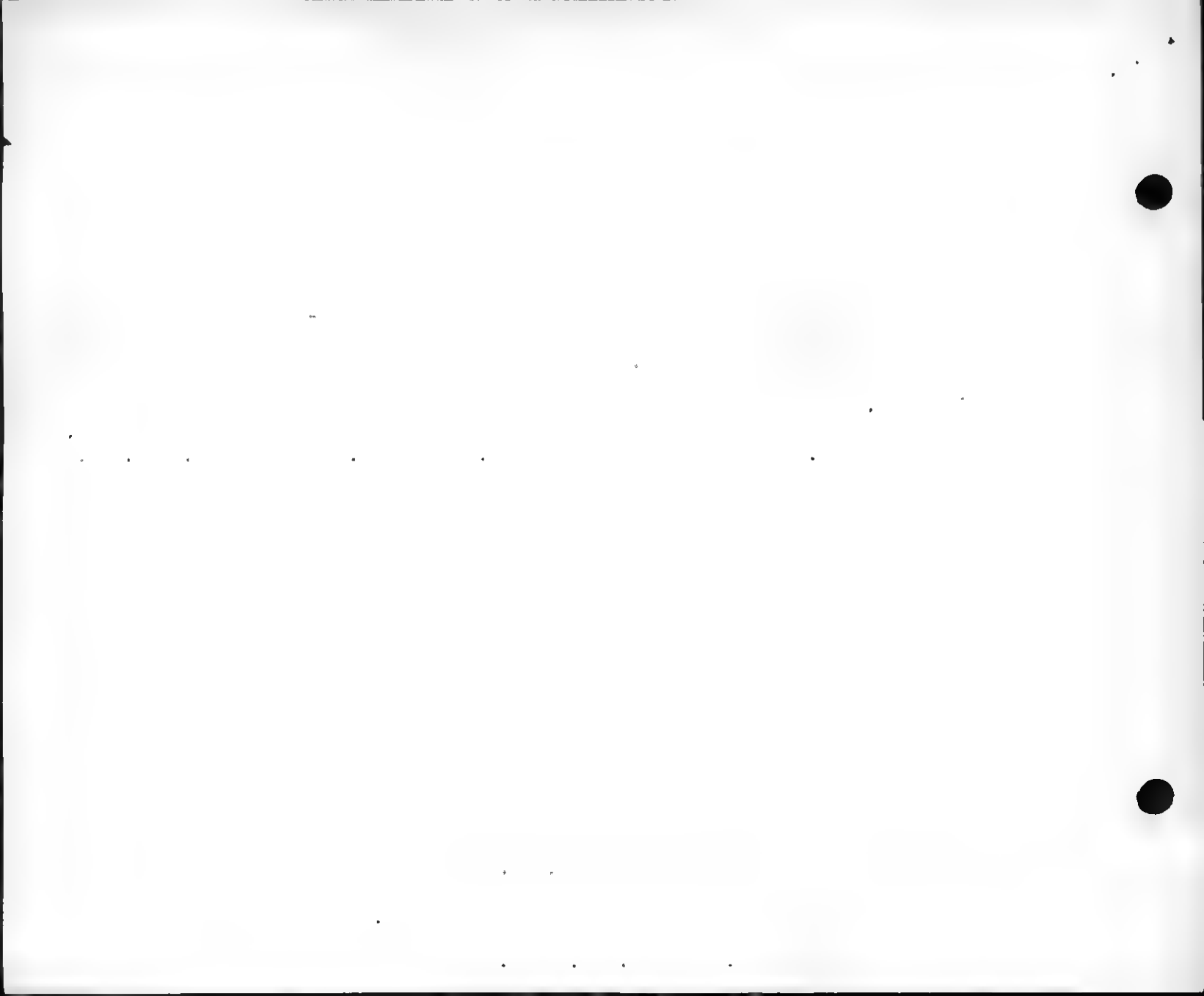
Item #23c Film #495 11/21/67 ph

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15810

15802

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Clinton Medical Center</b>		d. STREET ADDRESS <b>Box 634, Piscataway Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Leon Sherman Case</b>		4. DATE OF DEATH Month Day Year <b>11 12 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>27 Dec. 1913</b>
9. AGE (In years last birthday) <b>51 yrs</b>		10. UNDER 1 YEAR Months Days Hours Min <b>11 12 19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver - Pr. Geo's Co. Dept. Of</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Works</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ernest A. Case</b>		14. MOTHER'S MAIDEN NAME <b>Sophia A. Povagh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW. II</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mrs. Dorothy A. Windsor (Dan.) Rt. # 1. Box</b>		Address <b>Clinton, MD. 422</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) <b>Heart failure</b>			
DUE TO <b>Arteriosclerotic heart disease</b>			
(b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>11-13-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 15th, 67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Washingt. Nat'l Cem.</b>		23d. LOCATION (City or town) (County) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>	
ADDRESS <b>Simmons Bros. 1661-Gd. Hope Rd. SE. Wash., DC</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

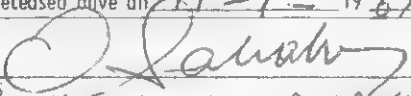
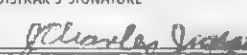


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

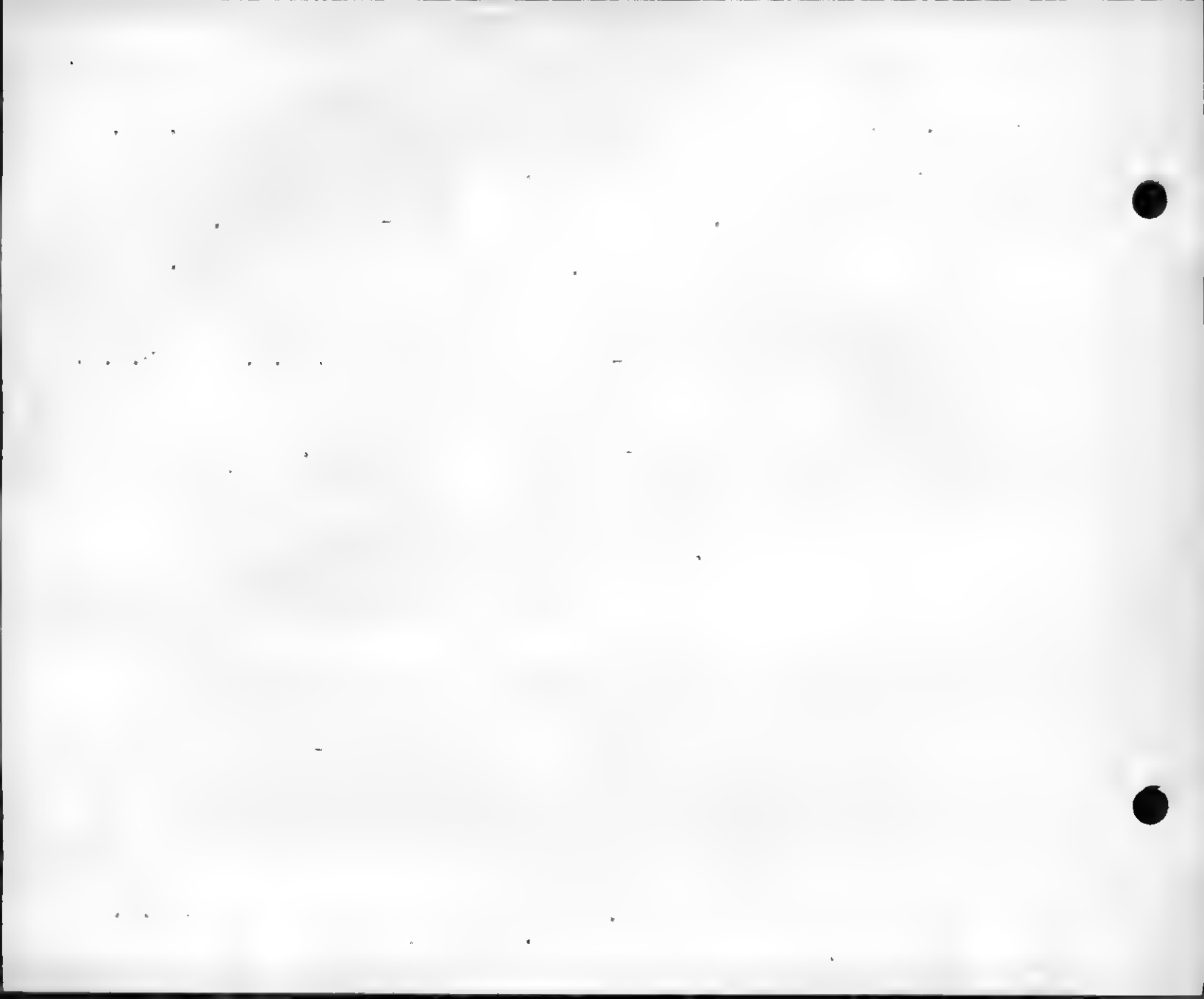
CERTIFICATE OF DEATH

15811

15803

1. PLACE OF DEATH a. COUNTY <b>Pr. Geo.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3020 - Laurel Ave.</b>		d. STREET ADDRESS <b>3020 - Laurel Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Catherine M. Clements</b>		4. DATE OF DEATH Month Day Year <b>Nov. 1 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/2/1878</b>
9. AGE (In years last birthday) <b>89</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ephraim McKenna</b>		14. MOTHER'S MAIDEN NAME <b>Johanna Corbett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-56-2477</b>	
17. INFORMANT <b>Miss Matilda E. Clements</b>		Address <b>(above address)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Liver</b> DUE TO (b) <b>Pulmonary Edema</b> DUE TO (c) <b>systemic sclerosis Heart Disease</b> stating the underlying cause last <b>Genito Urinary tract Infection</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>3 day</b> <b>6 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1965</b> to <b>11-1-1967</b> , that (I) (we) last saw the deceased alive on <b>11-1-1967</b> , and that death occurred at <b>9:30 M.</b> from causes and on the date stated above.			
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) <b>CHARLES SADIKYAN</b>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>6001 LANDOVER RD. Cheverly Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/6/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25. REC'D BY REGISTRAR DATE <b>NOV 8 1967</b> 25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

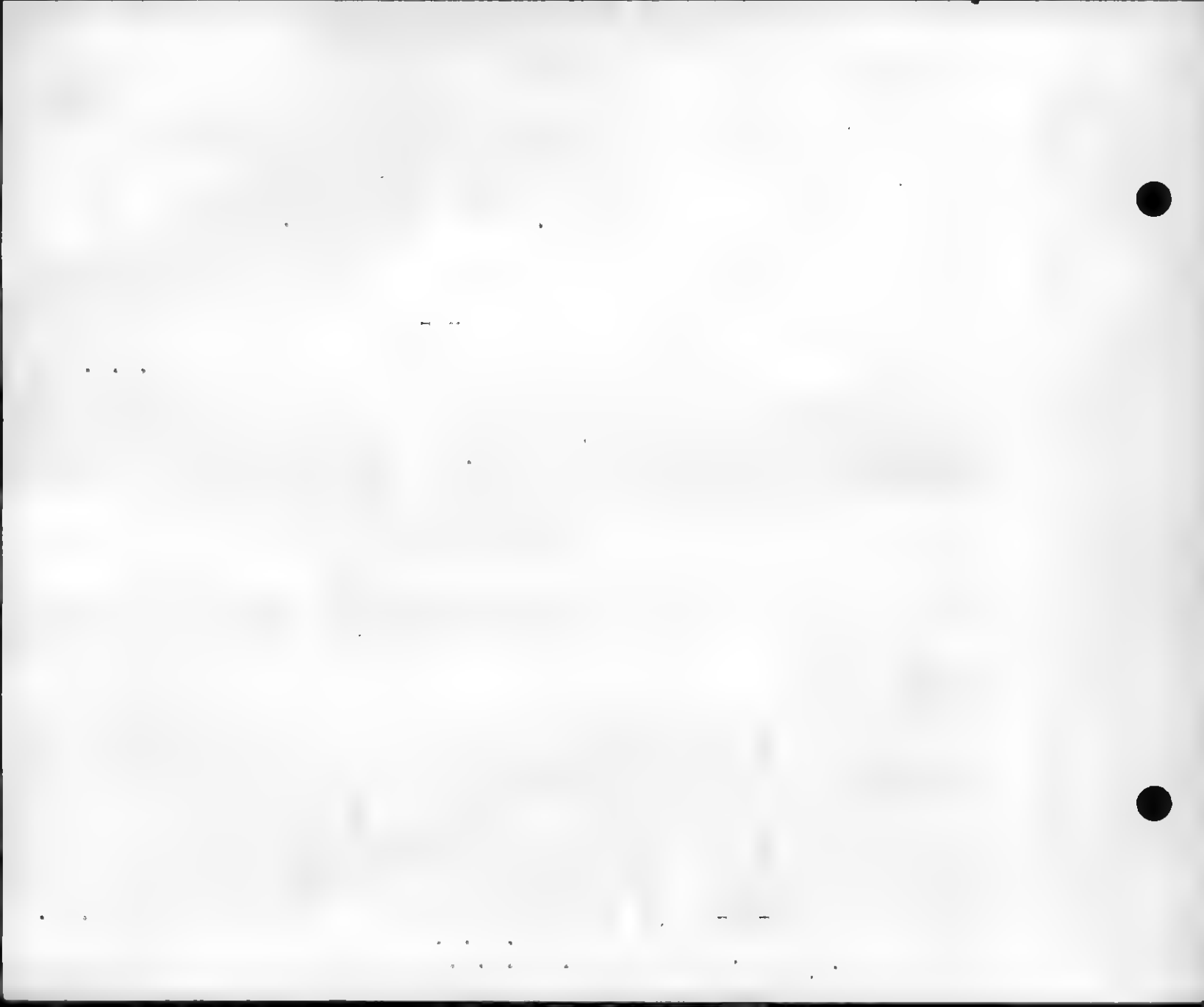
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1-66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b>		c. LENGTH OF STAY IN 1b <b>1 MONTH</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUITLAND NURSING HOME INC.</b>		d. STREET ADDRESS <b>6623 24TH. AVENUE</b>	
3 NAME OF DECEASED (Type or print) First <b>FORTUNATA</b> Middle <b>COLLELI</b> Last <b>COLLELI</b>		4 DATE OF DEATH Month <b>11</b> Day <b>15</b> Year <b>1967</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-6-68</b>
9. AGE (n years lost birthday) <b>99</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>15</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>ITALY</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>PETER GRECO</b>		14 MOTHER'S MAIDEN NAME <b>GATANA GERVERSIA</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO. <b>213-54-8120</b>	
17. INFORMANT <b>MRS. ROSE NASH</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>+++++</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>HYPERTENSION</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>4 WEEKS</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL ISCHEMIA</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/17</b> , 19 <b>67</b> , to <b>11/15</b> , 19 <b>67</b> ; that (I) (we) last saw the deceased alive on <b>10/17/67</b> , and that death occurred at <b>9:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Bruno Konec</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>BRUNO KONEC</b>		22d. ADDRESS <b>4400 SODAM P RD. SE. HARLOW HEIGHTS - MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11-18-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT OLIVET CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON D. C.</b>
24 FUNERAL DIRECTOR <b>Francis J. Collins</b>		25a. REC'D BY REGISTRAR <b>NOV 20 1967</b>	
ADDRESS <b>WASH. D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





FOR STATE HEALTH DEPT.

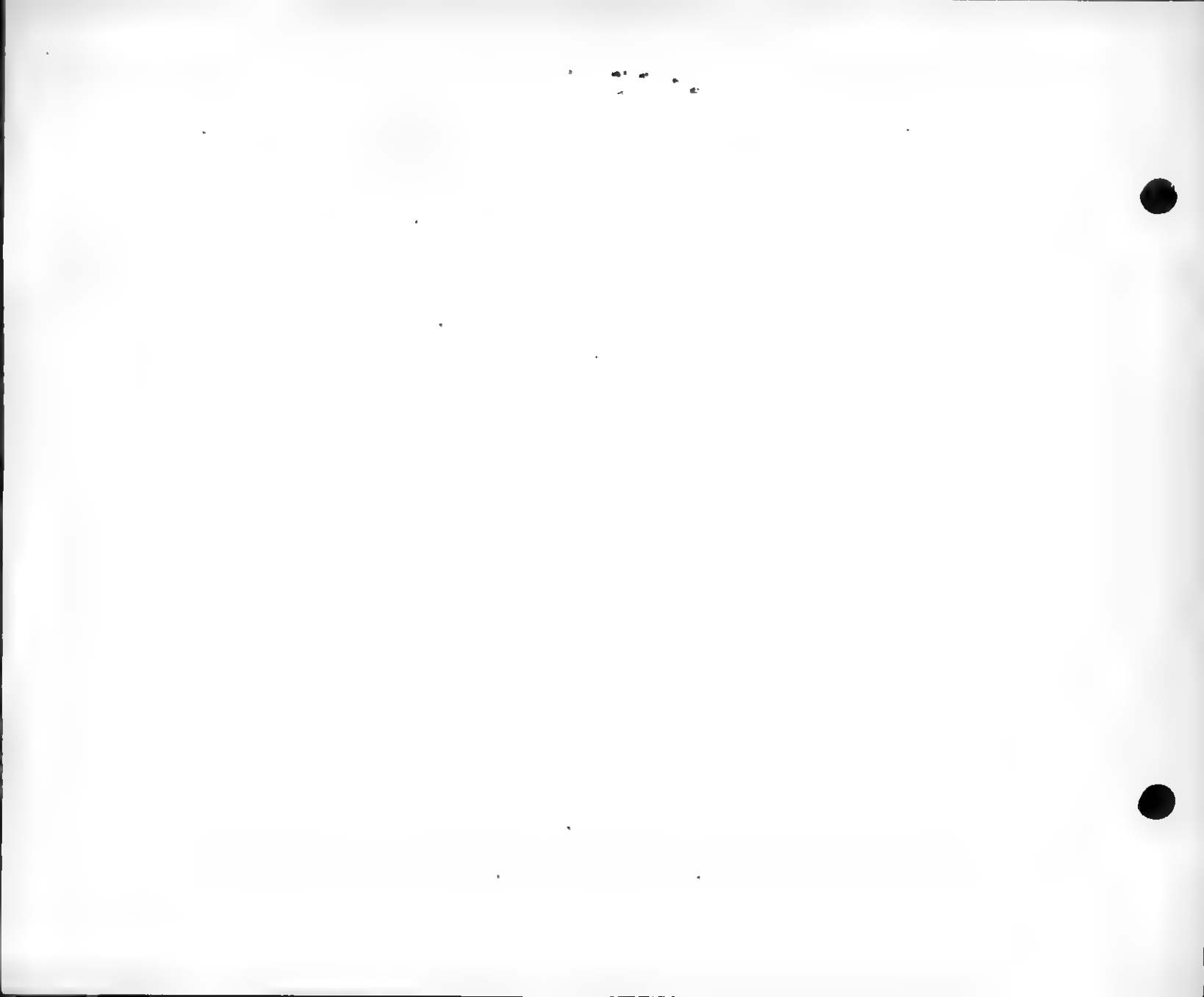
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15805

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> ✓			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN b. <b>2 1/2 mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>14101 Dub Drive</b>				d. STREET ADDRESS <b>14101 Dub Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lissa</b> Middle <b>Ann</b> Last <b>Collins</b>				4. DATE OF DEATH Month <b>11</b> Day <b>16</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 Aug. 1967</b>	9. AGE (In years last birthday) yrs. <b>2</b>	IF UNDER 1 YEAR Months <b>21</b> Days <b>21</b> Hours <b>Min</b>		IF UNDER 24 HRS Hours <b>Min</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>DR JAMES JOSEPH COLLINS</b>				14. MOTHER'S MAIDEN NAME <b>—</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>DR JAMES J COLLINS 14101 DUB DRIVE, LAUREL, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO _____ (b) <b>SDII</b> DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c. TIME OF INJURY Month, Day Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							22. DATE SIGNED
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		M.D. <b>Riverdale, Md.</b>		22. DATE SIGNED <b>11-17-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>Nov. 21, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SPRINGFIELD</b>		23d. LOCATION (City or Town) (County) (State) <b>MASS.</b>	
24. FUNERAL DIRECTOR <b>Charles Judge</b>		ADDRESS <b>550 WASH BVD, LAUREL, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15813

CERTIFICATE OF DEATH

15806

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince Georges</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN <u>4 mo</u> <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PINE VIEW CORRENTS</u>		d. STREET ADDRESS <u>1500 Oak View Drive</u>	
3 NAME OF DECEASED (Type or print) <u>BLANCHE L COLLIS</u>		4 DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-2-1883</u>
9 AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Britton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>236-16-3582-A</u>	
17. INFORMANT <u>M. HART, RD</u>		Address <u>5905 FISHER, WASH.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4xuv</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASIA</u> (c) <u>QVA.</u>			INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-13</u> , 19 <u>62</u> to <u>11-6</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>11-6</u> , 19 <u>67</u> , and that death occurred at <u>8 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Alfred R. Lapin</u> M.D.		22b. DATE SIGNED <u>11-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, MD</u>		22d. ADDRESS <u>CLINTON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-9-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bunker Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Martinsburg West Virginia</u>
24 FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u>		25a. REC'D BY REGISTRAR <u>NOV 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. 1. 1. 1. 1.

X

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

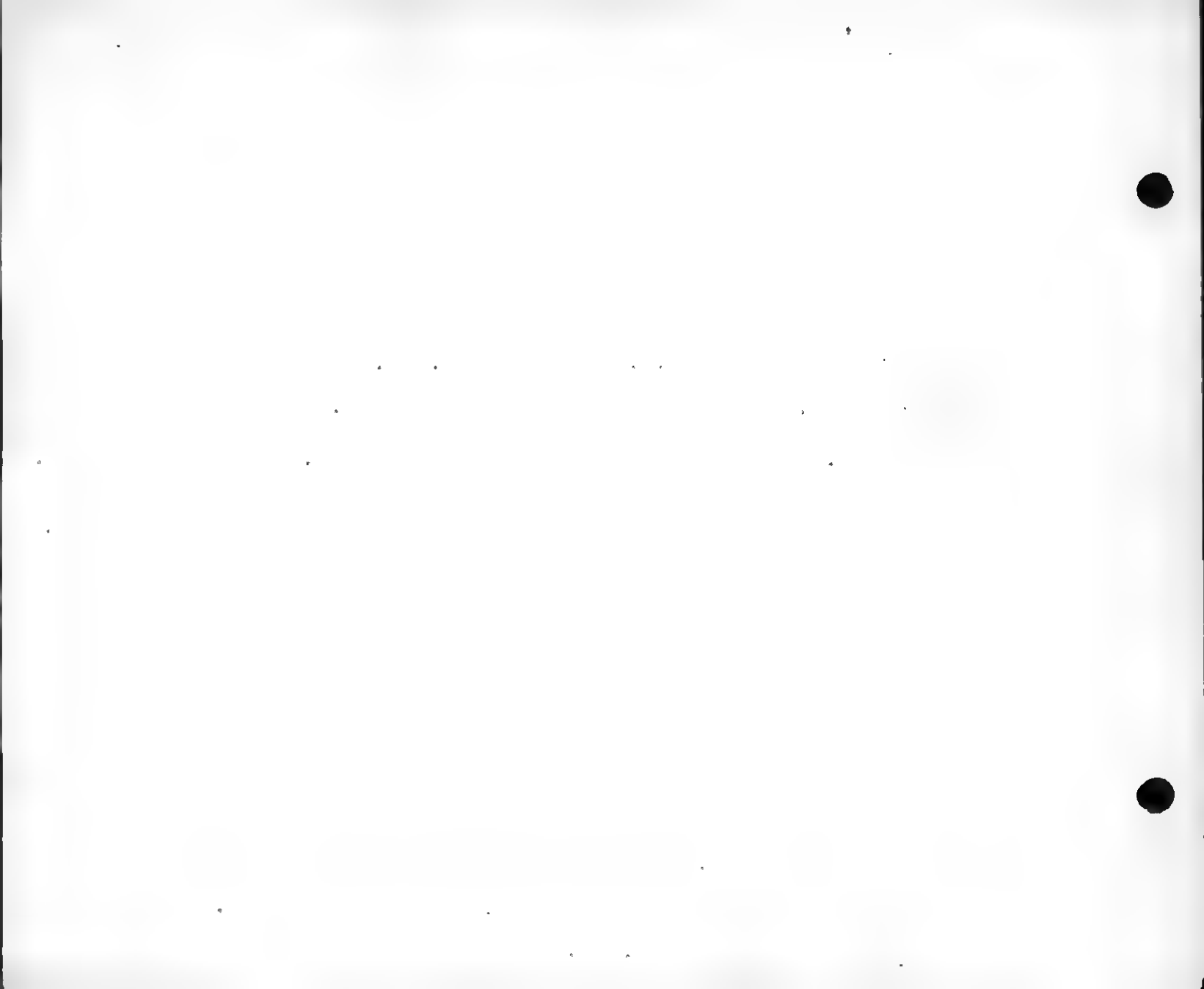
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>8066 87th. Avenue</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Glenn Weldon Dameron</b>		4 DATE OF DEATH Month Day Year <b>11 10 67</b>	
5 SEX <b>Male</b>	a. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 July 1910</b>
9 AGE (n years lost birthday) <b>57 yrs</b>		11 BIRTHPLACE (State or foreign country) <b>Ava. Mo.</b>	
10a. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Analyst</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N.S.A.</b>	
11 BIRTHPLACE (State or foreign country) <b>Ava. Mo.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Clarence W. Dameron</b>		14 MOTHER'S MAIDEN NAME <b>Cornellia E. Boone</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. etc.) <b>yes WW. II</b>		16 SOCIAL SECURITY NO <b>246-14-3512</b>	
17 INFORMANT <b>Mrs. Lavinia C. Dameron,</b>		Address <b>New Carrollton Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 6 mo.</b>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>11-10-67</b>	
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<b>Burial</b>	<b>11-13-67</b>	<b>Ivy Hill Cemetery</b>	<b>Alex., Va.</b>
24 FUNERAL DIRECTOR <b>Everly-Wheatley</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 14 1967</b>	
ADDRESS <b>Alex., Va.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



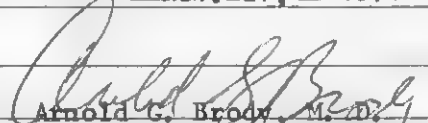

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

15815

15809

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1 PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>19 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Palmer Park</b> d. STREET ADDRESS <b>7401 85th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3 NAME OF DECEASED</b> (Type or print) First Middle Last <b>(Joseph) Guiseppa D'Arcangelo</b> <b>4. DATE OF DEATH</b> Month Day Year <b>Nov. 17, 19 67</b>				<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>11/20/91</b> <b>9. AGE</b> (In years lost birthday) <b>75</b> yrs <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Tire Sener</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Building</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Italy</b> <b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Zopito D'Arcangelo</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Filomena Dinofrio</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> <b>16. SOCIAL SECURITY NO</b> <b>579 05 7834</b> <b>17. INFORMANT</b> <b>7501 Halleck St. (son)</b> <b>Albert D'Arcangelo Washington D.C.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Very severe bronchial pneumonia, bilateral,</b> DUE TO <b>involving all lobes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe prurulent tracheal bronchitis</b> DUE TO (c) <b>Coronary Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour 'a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg, etc)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (he) (this hospital) attended the deceased from <u>Oct. 29, 1967</u>, to <u>Nov. 17, 1967</u>, that (he) (we) last saw the deceased alive on <u>Nov. 17, 1967</u>, and that death occurred at <u>8:00AM</u>, from causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b>  <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Arnold C. Brody, M.D.</b>				<b>22b. DATE SIGNED</b> <b>11/18/67</b> M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		<b>22d. ADDRESS</b> <b>Prince Georges General Hospital</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11/21/67</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olivet</b>		<b>23d. LOCATION (City or Town) (County) (State)</b> <b>Washington D.C.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Francis Gasch's Sons Hyattsville, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE NOV 22 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 	



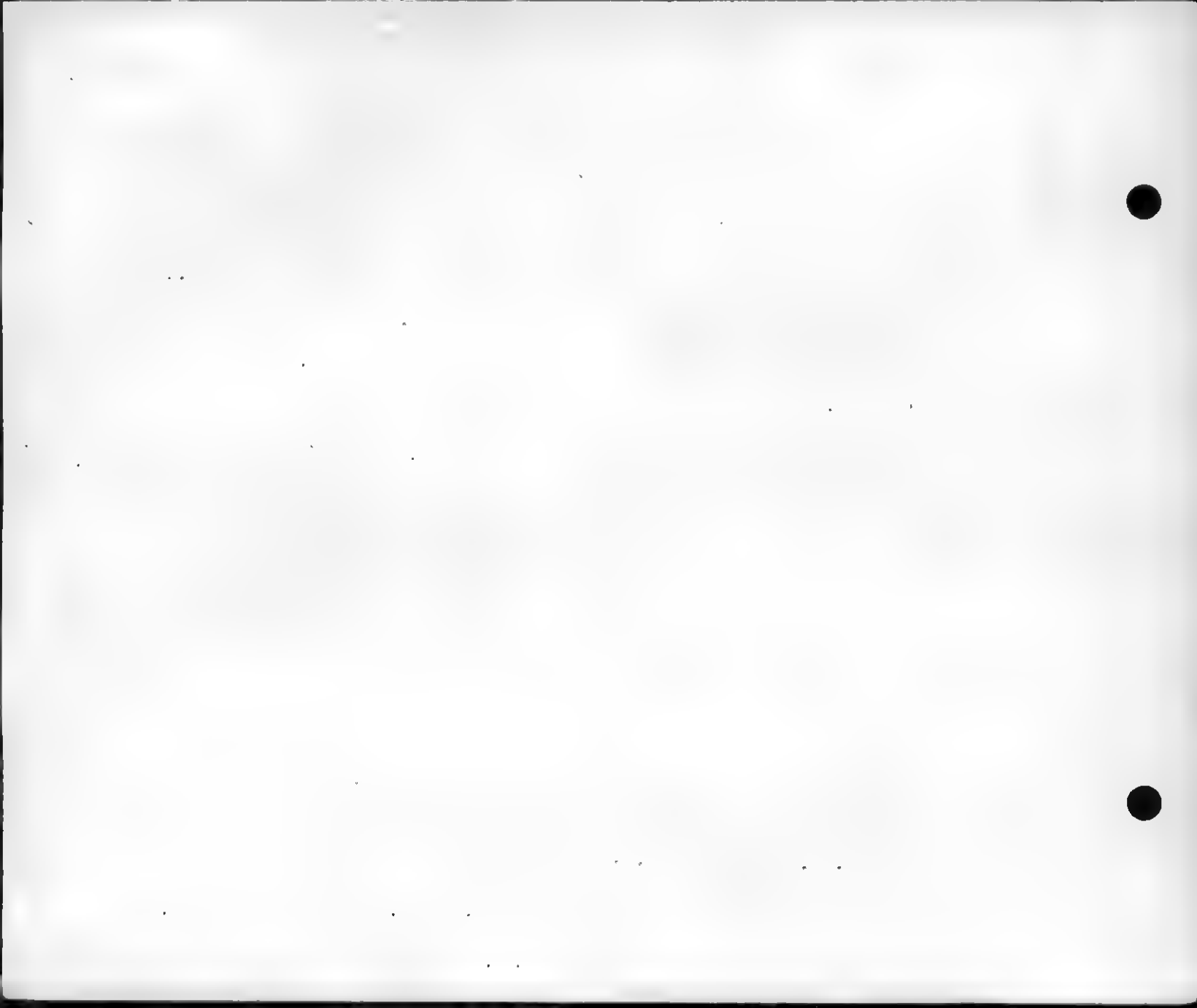


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items 23c & 23d, Film 9/11/66 rac											
15810											
15810											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>3 hrs 20 m</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>						d. STREET ADDRESS <b>3206 Tremont Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Paul GEORGE Daston</b>						4. DATE OF DEATH Month Day Year <b>19 Nov. 1967 19</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>17 Oct., 1921</b>		9. AGE (In years lost birthday) <b>46</b> yrs		10. F UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Profesaor</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Boston, Mass.</b>				12. C. TIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George P. Daston</b>						14. MOTHER'S MAIDEN NAME <b>Zenobia Zarapatis</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 10-2-42 to 8-21-45</b>				16. SOCIAL SECURITY NO. <b>032-09-1797</b>		17. INFORMANT Address <b>Marie P. Daston (Wife) 3206 Tremont Ave. Cheverly, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO (b) <b>Ventricular fibrillation</b> DUE TO (c) <b>Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH <b>15 m 7 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic carditis</b>								19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>12:50 AM 11-19-67</b> to <b>5:35 AM 11-19-67</b> that (I) (we) lost the deceased alive on <b>11-19-1967</b> , and that death occurred at <b>5:35 AM</b> from causes and on the date stated above.											
22a. SIGNATURE <b>Dr. W. Weihtraub, M.D.</b>						22b. DATE SIGNED <b>11-19</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. W. Weihtraub, M.D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>22 Nov. 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem. Arlington, Natl. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md. (County) (State)</b>			
24. FUNERAL DIRECTOR <b>Rinaldi Funeral Home</b>						25a. REC'D BY REGISTRAR <b>NOV 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

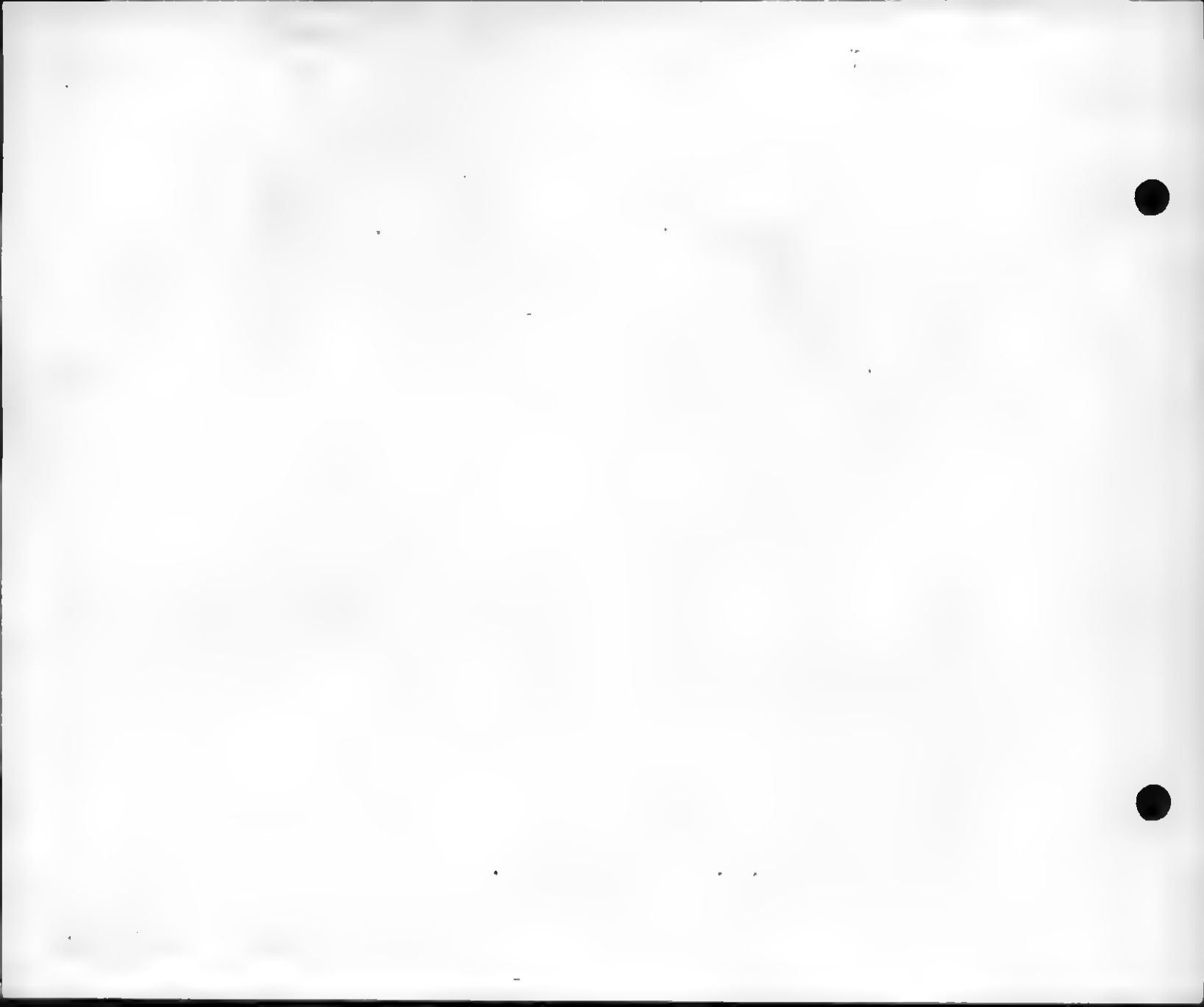
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>503 4 th. Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>PELTON</b> Last <b>Dauchy</b>				4 DATE OF DEATH Month <b>11</b> Day <b>27</b> Year <b>19 67</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>30 June 1926</b>	9. AGE (In years lost birthday) yrs. <b>41</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>dispatcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>cash stand</b>		11. BIRTHPLACE (State or foreign country) <b>Poughkeepsie N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carol Vail Dauchy</b>				14. MOTHER'S MAIDEN NAME <b>Liese Bauer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes 1944-1946</b>		16. SOCIAL SECURITY NO <b>12-20-1428</b>		17. INFORMANT <b>John Dauchy</b> Address <b>Laurel Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral lobar pneumonia</b> <b>7100</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>				22. DATE SIGNED <b>11-27-67</b>			
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<b>Burial</b>		<b>11-30-67</b>		<b>Loy Hill Cem</b>		<b>Laurel Md</b>	
24. FUNERAL DIRECTOR <b>Delbert Canadian</b>				25a. REC'D BY REGISTRAR <b>DEC 4 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>34 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>4221 30th St.</b>	
3. NAME OF DECEASED (Type or print) First <b>McKay</b> Middle <b>M.</b> Last <b>Dement</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>4,</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/12/05</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware Store</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Kennett, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George DeMont</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Kinder</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Peacetime</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Francis Smith (Sister)</b>		Address <b>Somerville, S.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, undifferentiated</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3mo.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1967</b> , to <b>Nov. 4, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 3 1967</b> and that death occurred at <b>12:30 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>William D. Rosson</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>11/4/67</b>
22c. PHYSICIAN'S NAME (Type) <b>William D. Rosson</b>		22d. ADDRESS <b>5701 - 85th Ave., Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11/7/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN</b>	23d. LOCATION (City or Town) (County) (State) <b>BURDEN'S BURR. MD.</b>
24. FUNERAL DIRECTOR <b>W. W. Chambers</b>		ADDRESS <b>Wash. D.C.</b>	25a. REC'D BY REGISTRAR <b>NOV 7 1967</b>
		25b. REGISTRAR'S SIGNATURE <b>Ochlanas Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

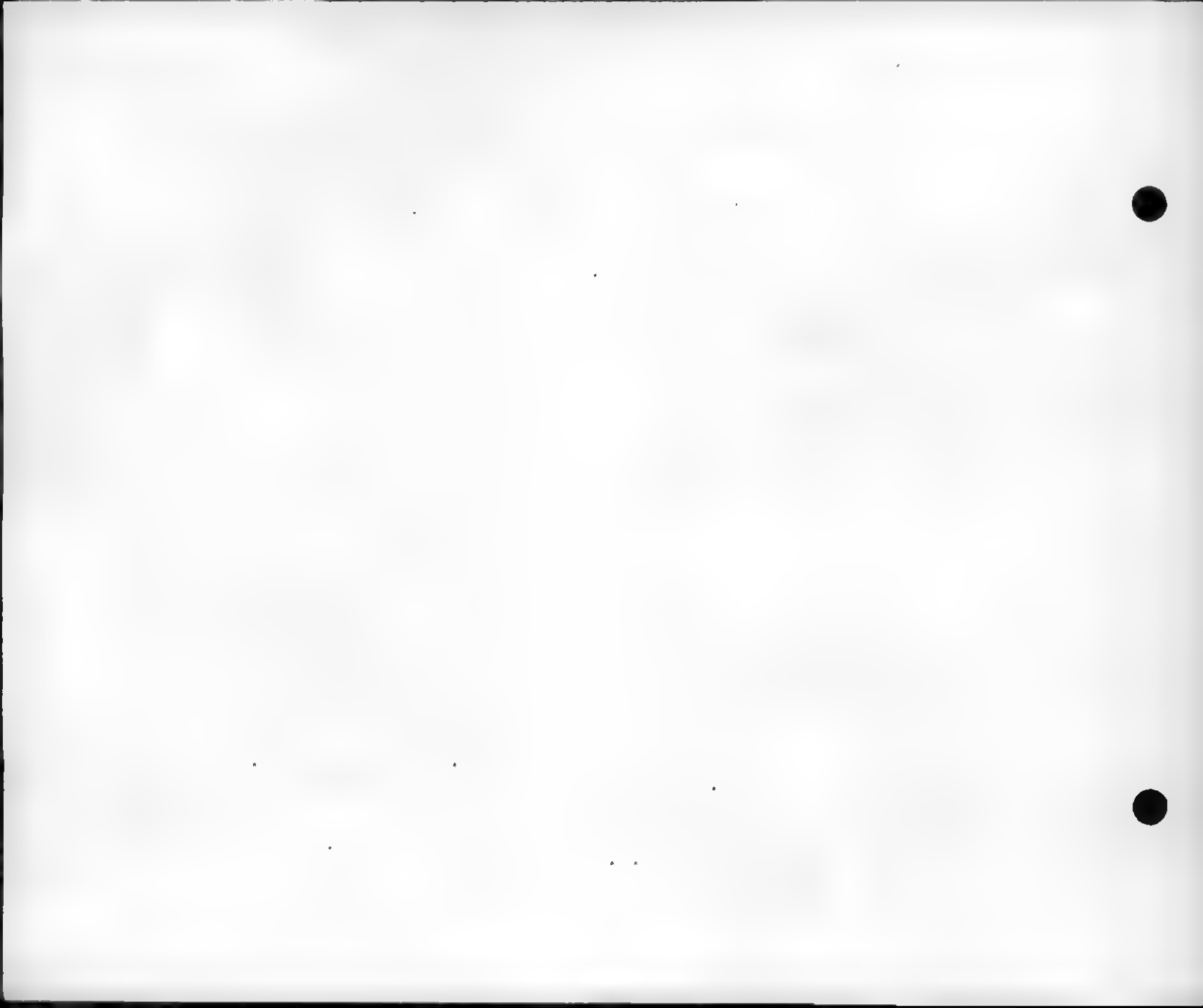
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 12 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>--</b>	
3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>N.</b> Last <b>Duckett</b>		4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/14/27</b> <b>7/4/39</b>
9. AGE (in years last birthday) <b>39</b> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret red) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>Charles County, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Duckett</b>		14. MOTHER'S MAIDEN NAME <b>Elise Roberson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Dorothy Shorter</b>		Address <b>Daughter</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrolyte imbalance</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Multiple Gastrointestinal urinary fistulas</b> DUE TO (c) <b>Regional ileitis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 17</b> , 19 <b>67</b> , to <b>Nov. 18</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov. 18</b> , 19 <b>67</b> , and that death occurred at <b>7:05A</b> M, from causes on and on the date stated above			
22a. SIGNATURE <b>R. Longoria</b>		22b. DATE SIGNED <b>11/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ricardo Longoria, M.D.</b>		22d. ADDRESS <b>Prince George's General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethel's Church Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Newtown Md</b>
24. FUNERAL DIRECTOR <b>Leroy E. Harvey Funeral Home</b>		25a. REC'D BY REGISTRAR <b>NOV 21 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>





## CERTIFICATE OF DEATH

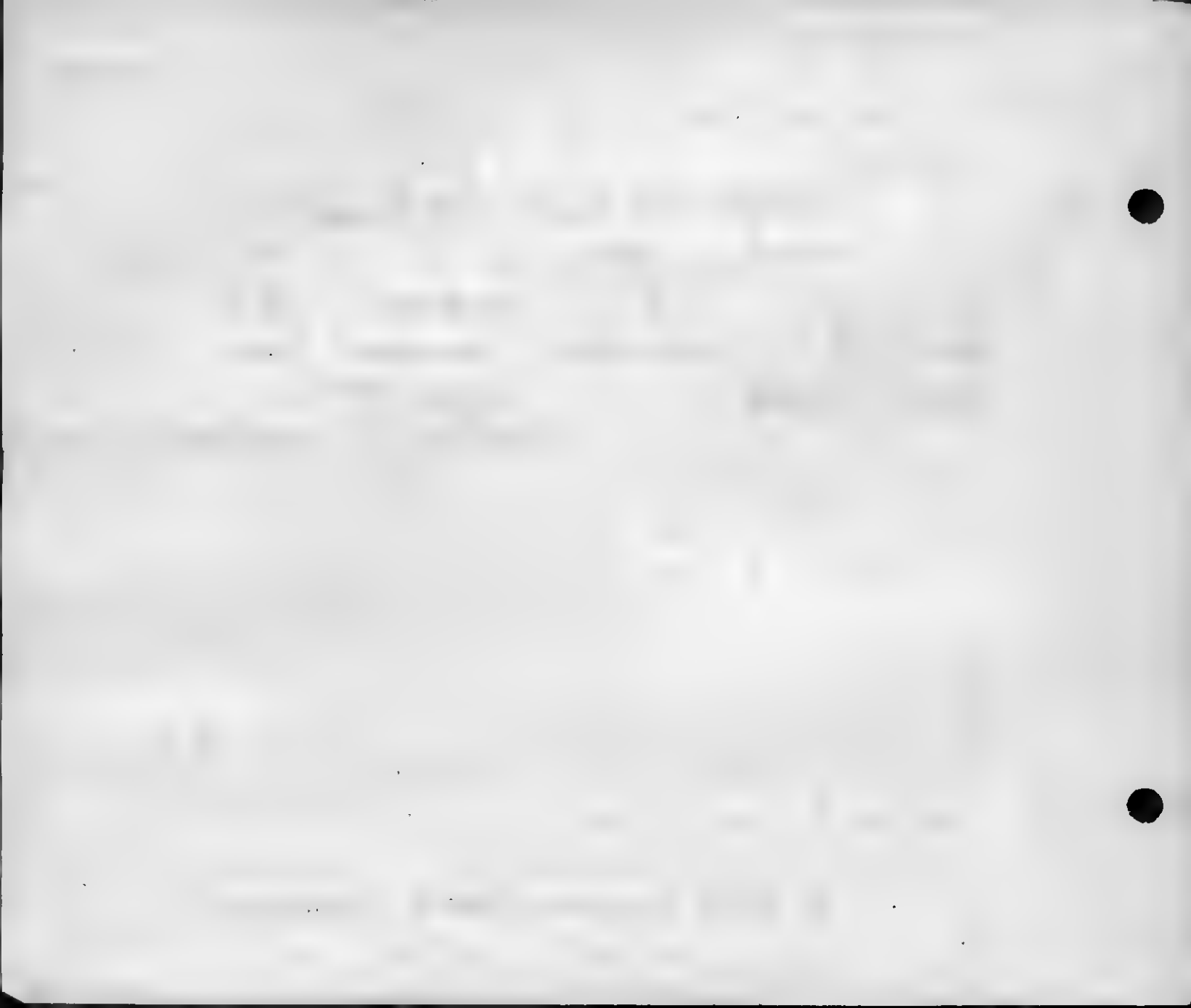
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>335 TALBERT AVE.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>LAUREL GEN. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LENA</u> <u>MARY</u> <u>ELDER</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>24</u> Year <u>1967</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 4, 1893</u>		9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>LOCK HAVEN, PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LORENZO NESTLERODE</u>		14. MOTHER'S MAIDEN NAME <u>ELLA HUFF</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>ETHEL J. MARTON, III DORSET RD. LAUREL, MD</u>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure + pneumonia</u> DUE TO (b) <u>Metastatic carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Same</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... <u>1967</u> to... <u>11-24</u> , 1967, that (I) (we) last saw the deceased alive on... <u>11-23</u> , 1967, and that death occurred at... <u>3:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edo's Pierandrea</u> M.D.				22b. DATE SIGNED <u>11/24/67</u>		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS <u>550 WASH BLVD.</u>				22e. REC'D BY REGISTRAR <u>MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Nov 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DUNNSTOWN CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>DUNNSTOWN</u> <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				25a. REC'D BY REGISTRAR <u>MD</u>			
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				25c. DATE <u>NOV 28 1967</u>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

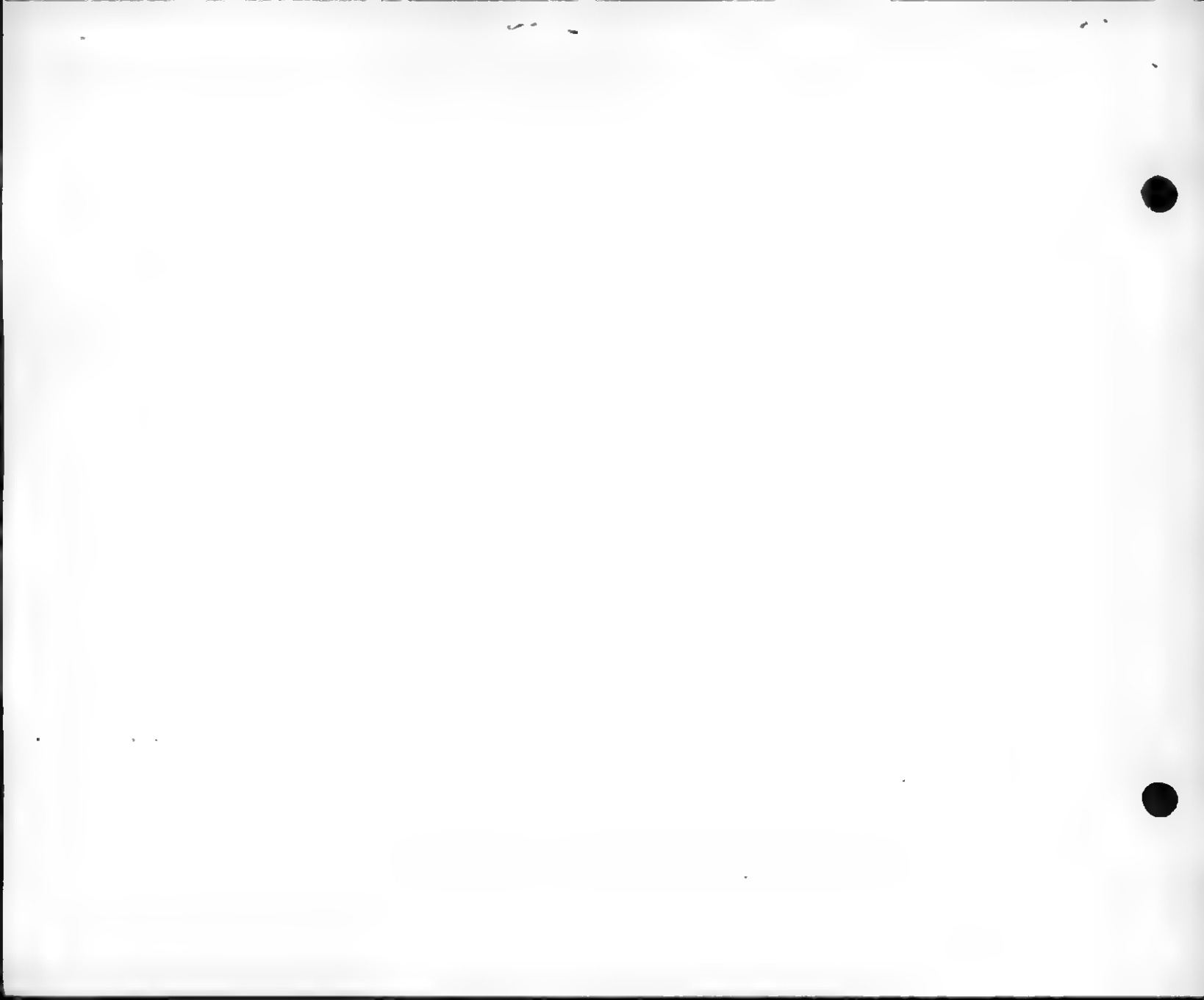
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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>six days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>601 58th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Tony Anthony Evans</b>			4. DATE OF DEATH Month Day Year <b>11 4 19 67</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-23-52</b>	9. AGE (In years last birthday) <b>15</b> yrs	IF UNDER 1 YEAR Months Days Hours Min <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Depressed skull fracture</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>hit by brick</b>			
20c. TIME OF INJURY Month, Day, Year hour a.m. <b>11:15pm</b> 10-28 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, b.d., etc.) <b>711 Eastern Ave. Fairmont Hts., P.G. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>11-6-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>11-9-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	
24. FUNERAL DIRECTOR <b>Baron Funeral Home</b>		ADDRESS <b>3001 K St. N.W.</b>		25a. RECEIVED BY REGISTRAR <b>NOV 10 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

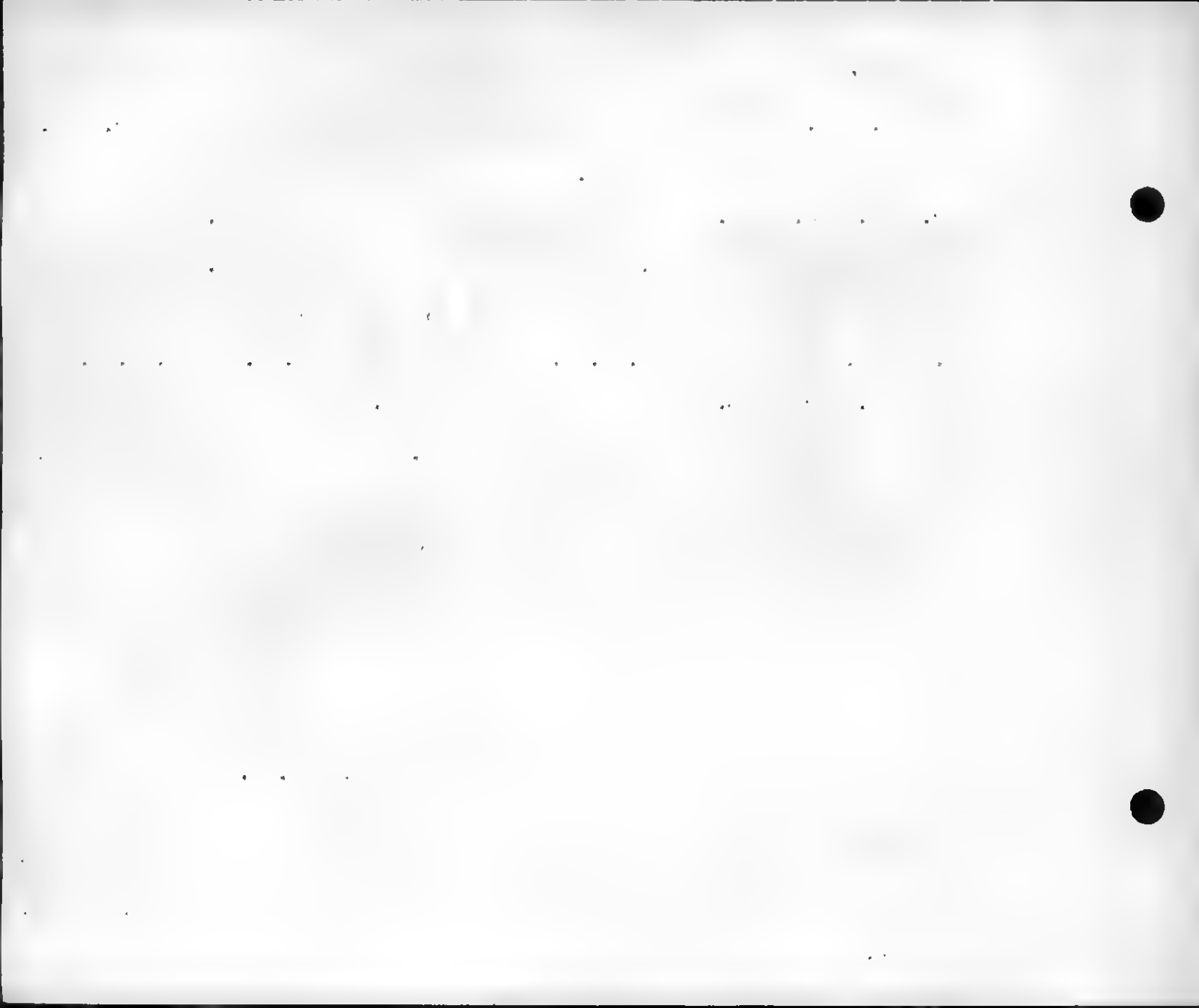
**CERTIFICATE OF DEATH**

15816

15822

1. PLACE OF DEATH a. COUNTY <b>Pr. Geo.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>2 Wks.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pr. Geo. Gen. Hosp.</b>				d. STREET ADDRESS <b>3717 Shepard Street.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD F. FARLEY</b> First Middle Last				4. DATE OF DEATH <b>Nov. 9 19 67</b> Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 2, 1892</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>		12. CIT ZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Engr.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Penn. R. R.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>	
13. FATHER'S NAME <b>Edward F. Farley Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Ella A. Lott</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>717 07 8512</b>		17. INFORMANT Address <b>Ariel A. Farley Wife Same as # 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>26 Oct</b> , 19 <b>67</b> , to <b>9 Nov</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8 Nov</b> , 19 <b>67</b> , and that death occurred at <b>3:20 A.M.</b> from <b>MI</b> on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED <b>11/9/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Francis Gasch's Sons</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/13/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Francis Gasch's Sons Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 14 1967</b>		25b. REGISTRAR'S SIGNATURE 	
23d. LOCATION (City or Town) (County) (State) <b>Suitland P.G. Md.</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)  
25M 1/67

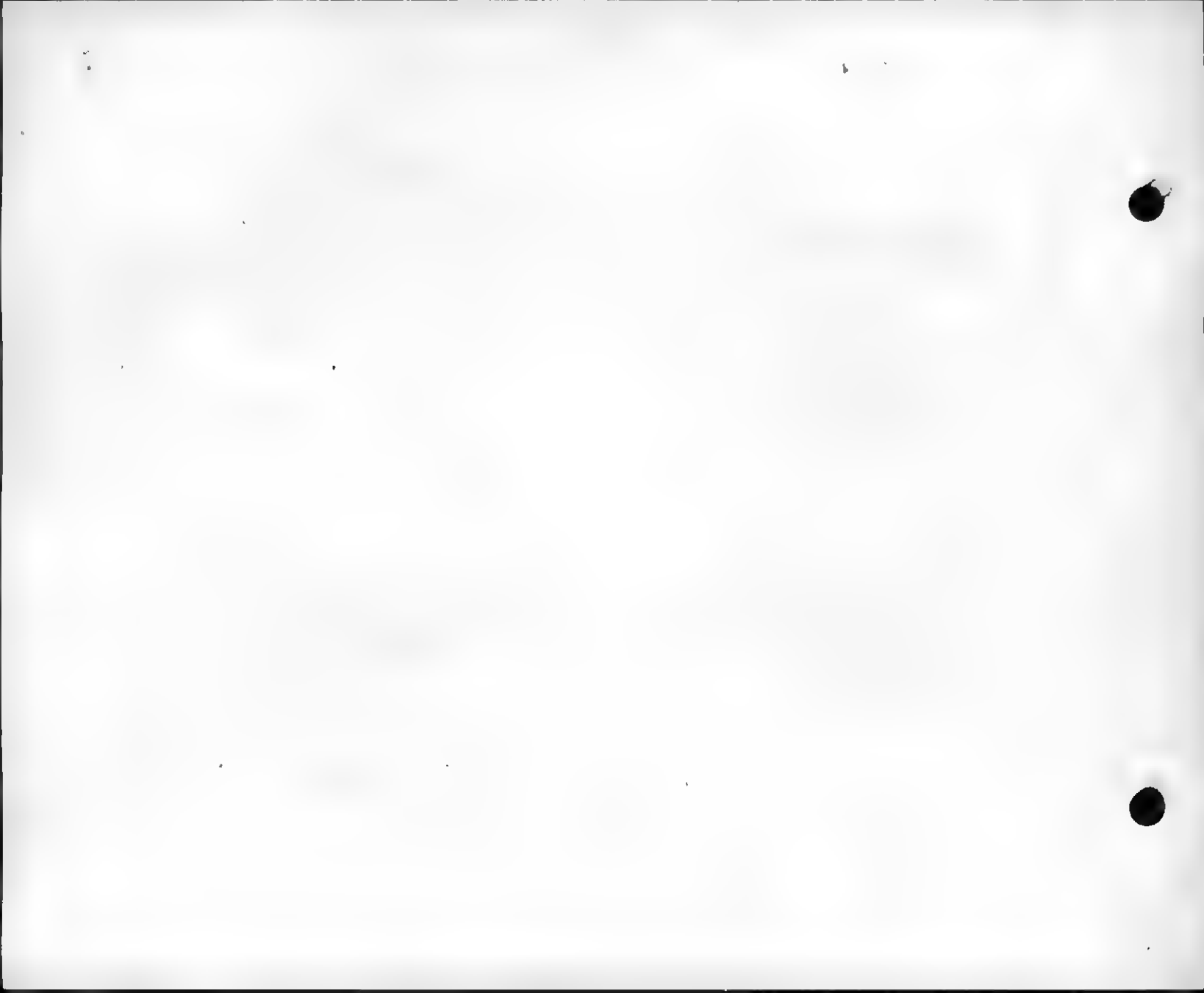
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15823

CERTIFICATE OF DEATH

15817

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb 4 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham,		d. STREET ADDRESS 9308 Calanda Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Betty S. Fechtig		4. DATE OF DEATH Month Day Year November 11 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-1904
9. AGE (In years last birthday) 63 yrs		10. UNDER 1 YEAR Months Days Hours Min	11. UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Smith, Unknown		14. MOTHER'S MAIDEN NAME Unknown Elizabeth Graham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Medical Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) CARCINOMA OF ESOPHAGUS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 6 MOS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 7, 1967, to Nov. 11, 1967, that (I) (we) last saw the deceased alive on Nov. 11, 1967, and that death occurred at 9:45 AM, from causes and on the date stated above			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 11-12-67	
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN		22d. ADDRESS RIVERDALE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-15-67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Lee Funeral Home		25a. RECTORY REGISTRAR DATE NOV 14 1967	
ADDRESS Washington, D.C.		25b. REGISTRAR'S SIGNATURE James Judge	





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

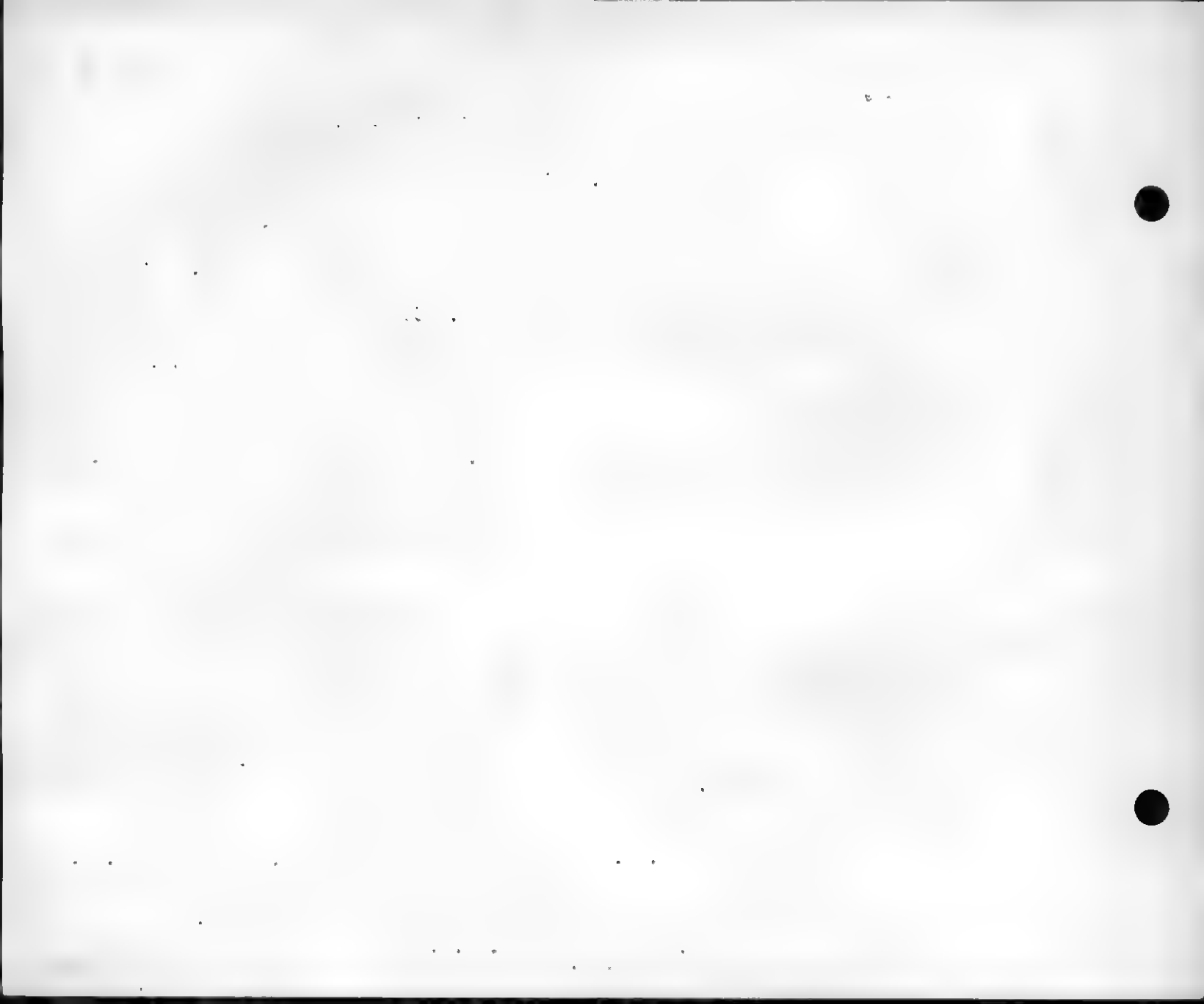
15824

15818

1 PLACE OF DEATH a COUNTY <b>Prince Georges</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b STATE <b>District of Columbia</b> c COUNTY <b>n/a</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d STREET ADDRESS <b>2634 Woodley Place, NW</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Ann Feeney</b>		4. DATE OF DEATH Month Day Year <b>Nov. 29, 19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1882</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Oaklahoma</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Thomas Archibald</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>573-01-2395D</b>	
17. INFORMANT <b>Mrs. Rubyn Bonnington - See Item No. 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac insufficiency</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) <del>physician</del> attended the deceased from <b>Nov 15</b> , 19 <b>67</b> , to <b>Nov. 29</b> , 19 <b>67</b> , that (I) <del>last</del> saw the deceased alive on <b>Nov. 29</b> , 19 <b>67</b> , and that death occurred at <b>8:15AM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Peter Duus</b>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <b>Peter Duus, M. D.</b>		22d ADDRESS <b>6124 Central Ave. Capitol Hghts. Md. 20027</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b DATE THEREOF <b>12-2-1967</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>	
24 FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.</b>		25a REC'D BY REGISTRAR <b>DEC 4 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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18

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #17 Film #G394 11/15/67 ph

15825

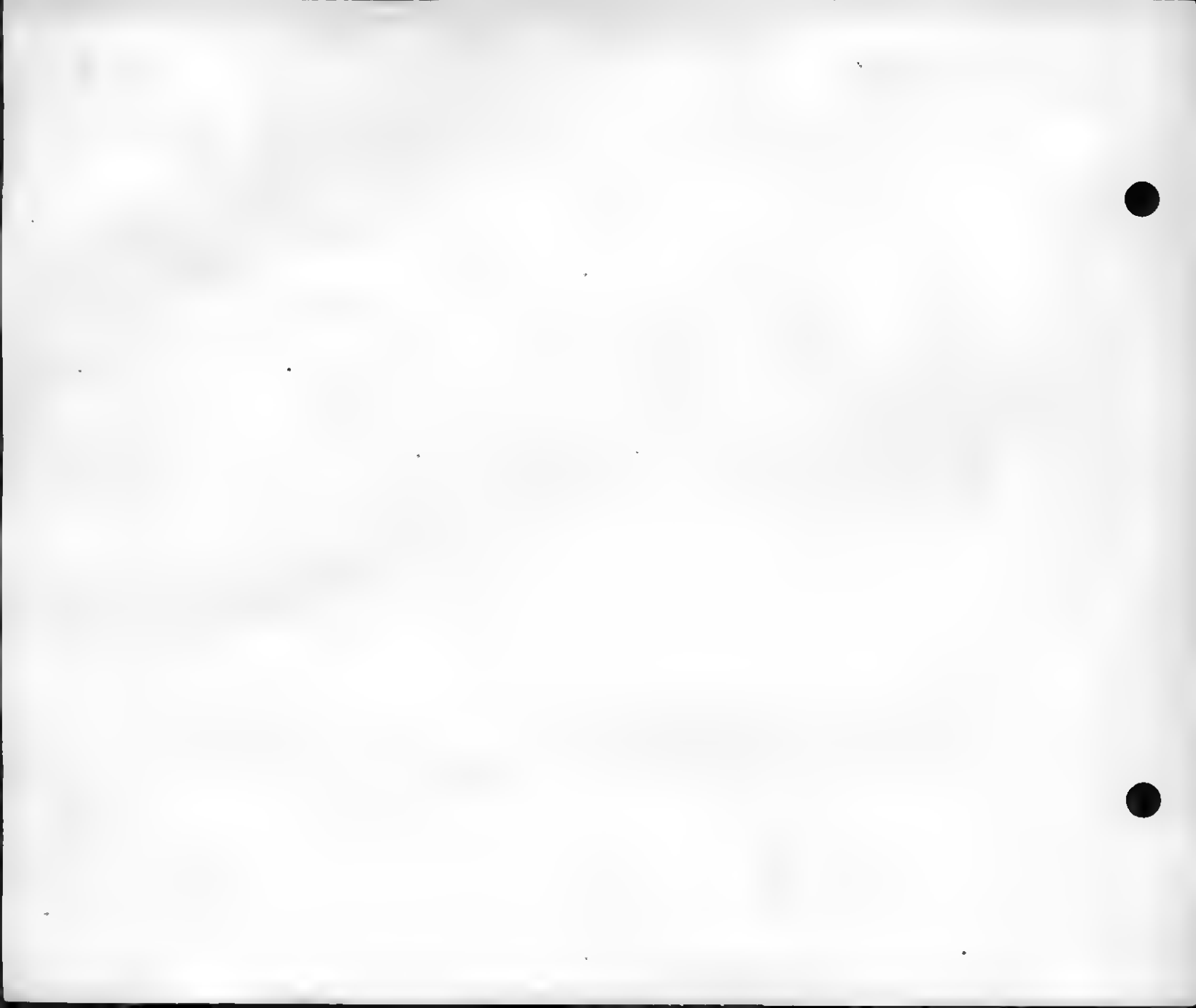
CERTIFICATE OF DEATH

15819

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY in 1b <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>149 Westway Road</b>	
3. NAME OF DECEASED (Type or print) <b>Stanley W. Fink</b>		4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 18, 1913</b>
9. AGE (In years last birthday) <b>54</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Govt. Official</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Labor</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Allentown, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Fink</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Dougherty</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>171-05-8379</b>	
17. INFORMANT <b>Margaret G. Fink</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4201</b> DUE TO <b>Myocardial infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>18 months</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-3-</b> , 19 <b>67</b> , to <b>11/4/67</b> , 1967, that (I) (we) last saw the deceased alive on <b>11-3-</b> , 19 <b>67</b> , and that death occurred at <b>5:17 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Hans Wodak</b>		22b. DATE SIGNED <b>11-4-1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>HANS WODAK</b>		22d. ADDRESS <b>GREENBELT PROF. BLDG. GREENBELT</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/7/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grandview Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Allentown Penna.</b>
24. FUNERAL DIRECTOR <b>F. GASCH'S &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>NOV 6 1967</b>	
ADDRESS <b>HYATTSVILLE, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Richard J. Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

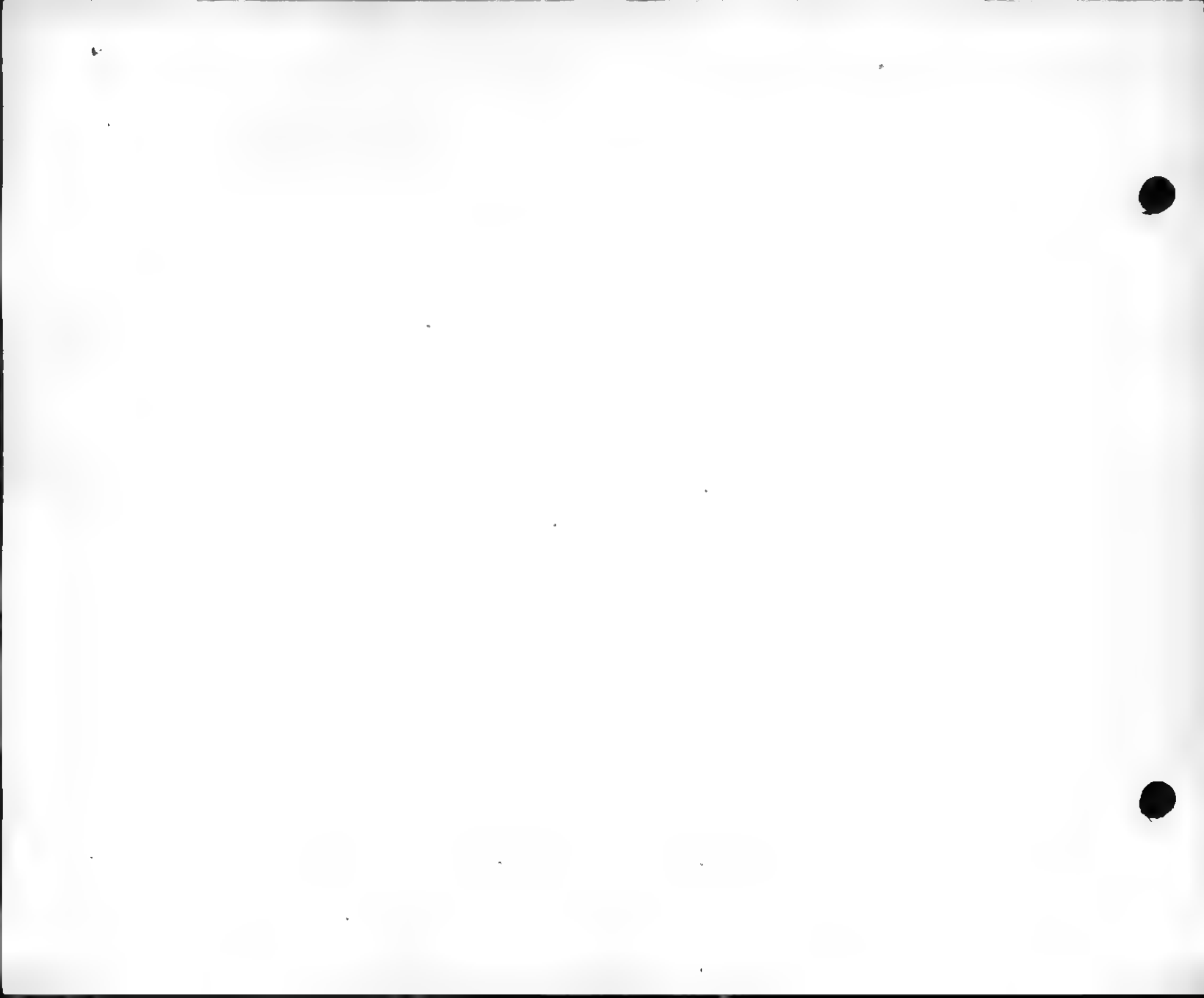
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VR A15ME  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		a. STREET ADDRESS <b>4708 Hamilton Street</b>	
3. NAME OF DECEASED (Type or print) <b>Michael Joseph Fitzgerald</b>		4. DATE OF DEATH <b>11 7 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 Aug. 1923</b>
9. AGE (In years last birthday) <b>44</b> yrs		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AUTOMOBILE INSPECTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. GOVT.</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MICHAEL J. FITZGERALD</b>		14. MOTHER'S MAIDEN NAME <b>MARY C. YOUNG</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> <b>WW II</b>		16. SOCIAL SECURITY NO <b>577-28-7689</b>	
17. INFORMANT <b>Virginia Fitzgerald</b>		Address <b>4708 Hamilton St Edmonston, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive intra cerebral hemorrhage</b> DUE TO <b>Hypertensive vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>11-8-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL, SPEC. IN	23b. DATE THEREOF <b>NOV 11 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEM</b>	23d. LOCATION (City or Town) (County) (State) <b>WHEATON, MARYLAND</b>
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS Co. RIVERDALE, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>NOV 13 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15827

CERTIFICATE OF DEATH

15821

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>16+ days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>5307 Crittenden St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Annie Elizabeth Freshman</b>		4. DATE OF DEATH Month Day Year <b>Nov. 10, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/16/85</b>
9. AGE (In years lost birthday) <b>81</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Matthew Walsh</b>		14. MOTHER'S MAIDEN NAME <b>Mary Gath</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>218 09 1102</b>	
17. INFORMANT <b>Mary A. Murray Same as #2 (daughter)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Peritonitis</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>perforated bowel</b> DUE TO (c) <b>Carcinoma of Recto sigmoid</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) ( <del>we</del> ) attended the deceased from <b>April</b> , 19 <b>52</b> , to <b>Nov. 10</b> , 19 <b>67</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Nov. 10</b> , 19 <b>67</b> , and that death occurred at <b>2:25 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Barry Rosenberg</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Barry Rosenberg, M. D.</b>		22d. ADDRESS <b>6501 Landover Rd., Cheverly, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/13/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	23d. LOCATION (City or town) (County) (State) <b>Colmar Manor P.G. Md.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 13 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

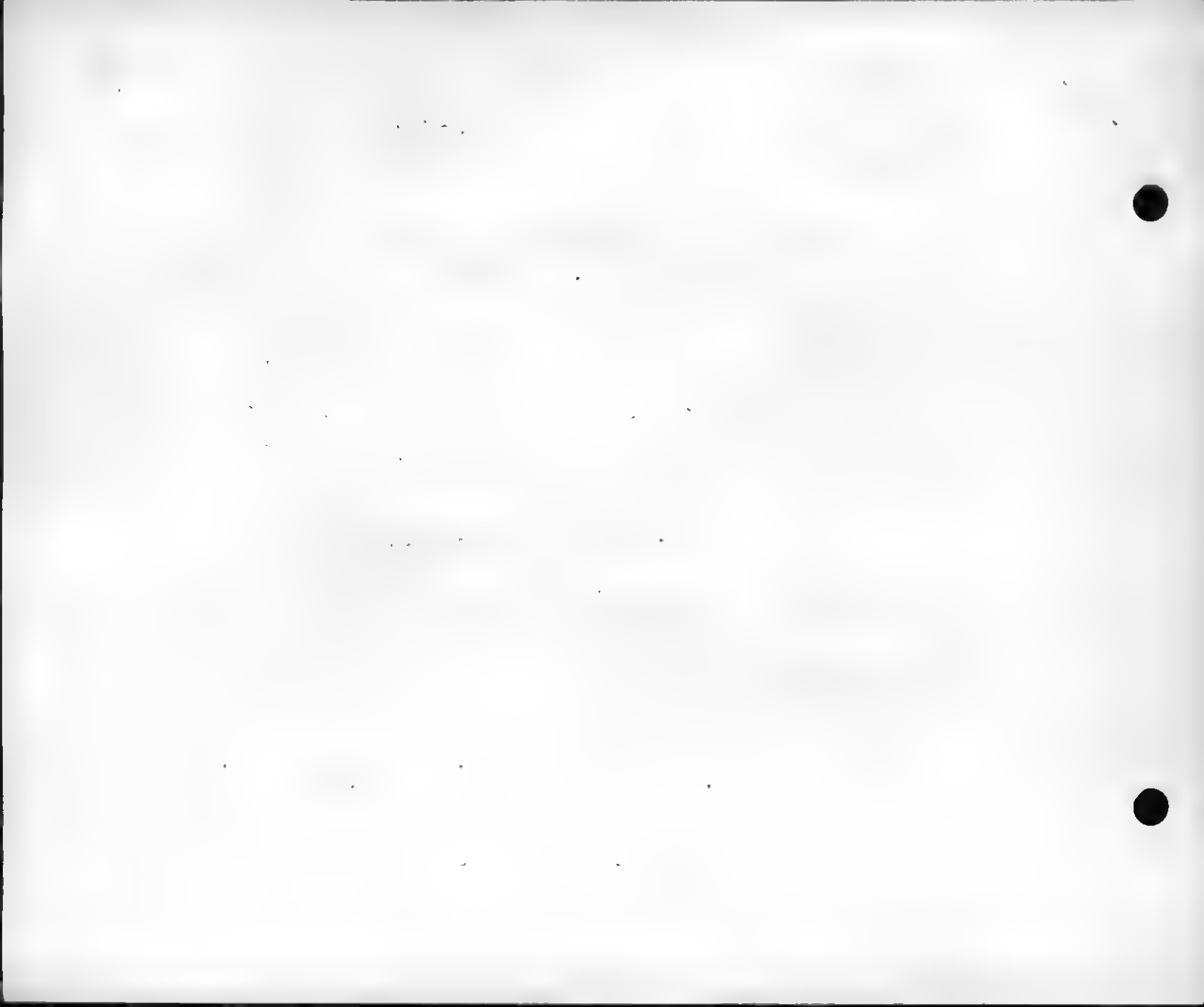
15822

15822

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carmody Hills</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>511 732nd Place</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Eldridge R. Fleshman</b>		4 DATE OF DEATH Month Day Year <b>November 11, 1967</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>6-16-22</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>	9. AGE (In years lost birthday) <b>45 yrs</b>
11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIE FLESHMAN</b>		14. MOTHER'S MAIDEN NAME <b>LOLA M. ROWLS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>235-26-2609</b>	
17. INFORMANT <b>IRENE FLESHMAN</b>		Address <b>6347 64th AVE. RIVERDALE, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Coma</b> <b>5810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bleeding Esophageal Varices</b> DUE TO (c) <b>Cirrhosis of the Liver</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from <b>Nov. 3, 1967</b> , to <b>Nov. 11, 1967</b> , that (H) (we) last saw the deceased alive on <b>Nov. 11, 1967</b> , and that death occurred at <b>2:05p.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>R. Longoria</b>		22b. DATE SIGNED <b>11-13-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ricardo Longoria, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-15-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Trinit Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>Waldorf, Chab, Md.</b>
24. FUNERAL DIRECTOR <b>Hend Funeral Home, Waldorf, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 17 1967</b>	25b. REGISTRAR'S SIGNATURE <b>O'Charles Judge</b>



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

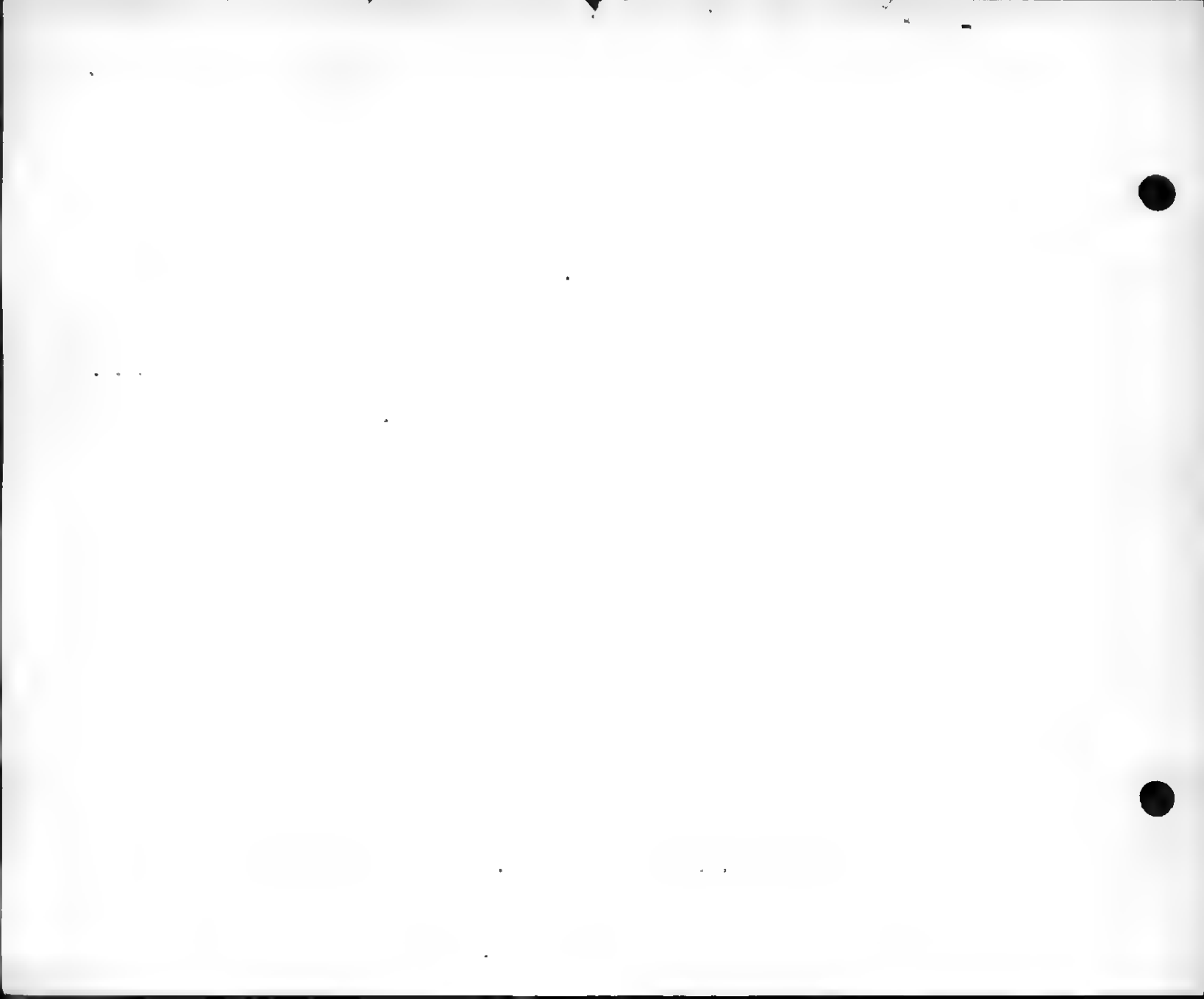
Items 1-8-21 Film 396 1-9-68 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15823

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15823

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>Box 204 8th. Street</b>			
3. NAME OF DECEASED (Type or print) <b>Robert (Quinton T.) Foote</b>				4. DATE OF DEATH Month <b>11</b> Day <b>7</b> Year <b>19 67</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 Oct. 1967</b>		9 AGE (n years last birthday) <b>13</b>	IF UNDER 1 YEAR Months <b>13</b> Days <b>13</b> Hours <b>13</b> Min <b>13</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11 BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLIFTON FOOTE</b>				14. MOTHER'S MAIDEN NAME <b>EMMA I. THOMAS</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NONE NO</b>				16 SOCIAL SECURITY NO <b>NO</b>		17 INFORMANT <b>CLIFTON FOOTE - BOWIE, MARYLAND</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Interstitial pneumonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>SDII</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b> EXAMINER'S NAME (Type)				22. DATE SIGNED <b>11-9-67</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>11-11-67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>		23d LOCATION (City or Town) (County) (State) <b>Prince George, Maryland</b>	
24. FUNERAL DIRECTOR <b>John T. Rhines Co.</b>				25a REC'D BY REG. STRAR <b>NOV 13 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

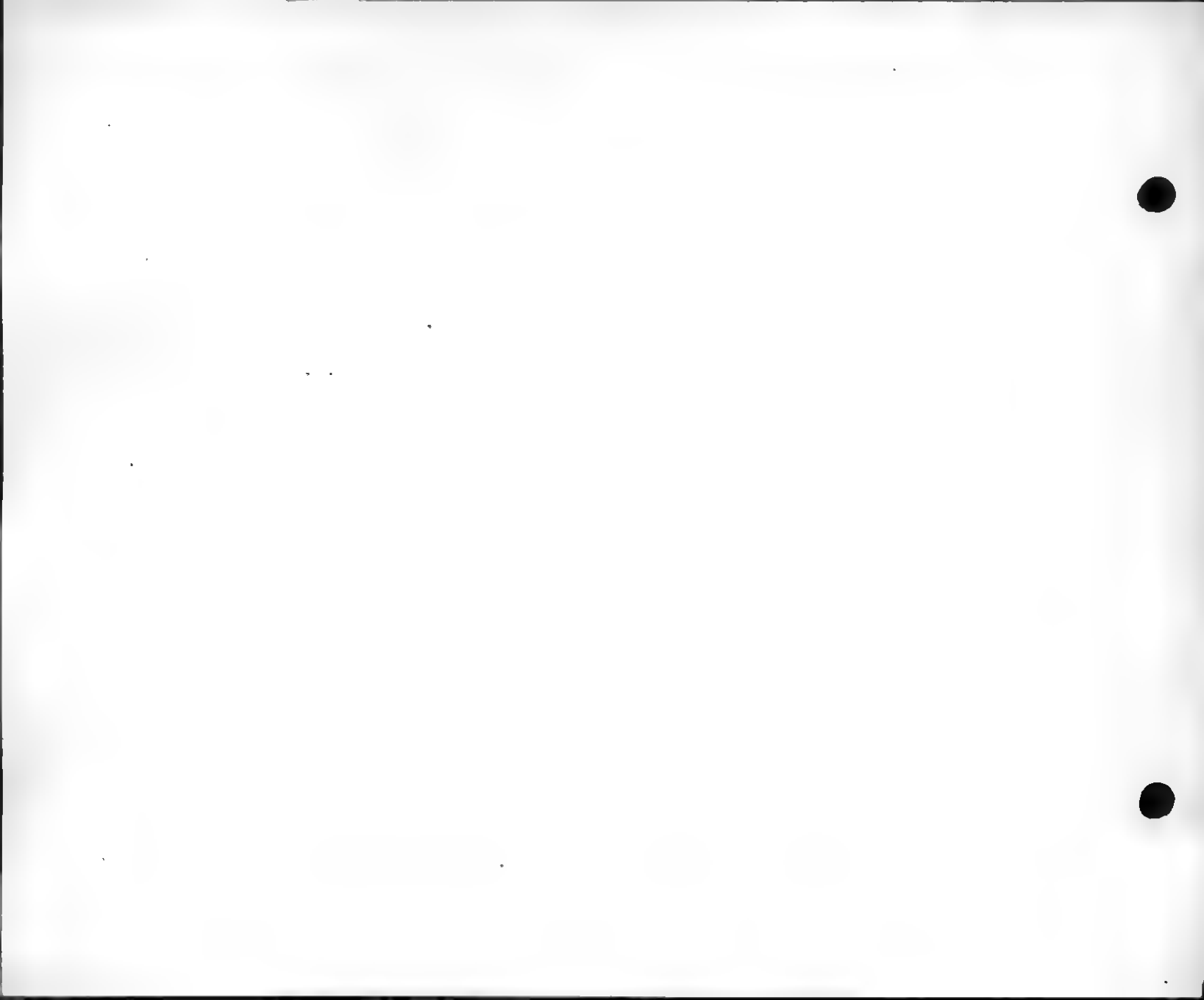
15830

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15824

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admision) a STATE <b>Maryland</b> b COUNTY <b>Prince George's</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c LENGTH OF STAY IN 1b <b>DOA</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d STREET ADDRESS <b>4709 Greenbelt Road</b>	
3 NAME OF DECEASED (Type or print) <b>Alexandra Forsythe</b>		4 DATE OF DEATH <b>11 13 19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>26 Oct. 1967</b>
9 AGE (n years last birthday) <b>11</b>		IF UNDER 1 YEAR <b>18</b> IF UNDER 24 HRS <b>18</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Claude Taylor</b>		14 MOTHER'S MAIDEN NAME <b>Elexis Forsythe</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Prince George's Co. Welfare Board.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>7952</b> IMMEDIATE CAUSE (a) <b>SDIT</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>SDIT</b> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o m p m <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>11-14-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11-16-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Sanage Cem</b>	23d LOCATION (City or Town) (County) (State) <b>Sanage Md.</b>
24 FUNERAL DIRECTOR <b>De Witt Danardman</b>		25a REC'D BY REGISTRAR <b>Charles Judge</b> 25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
ADDRESS <b>Sanage Md.</b>		DATE <b>NOV 22 1967</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

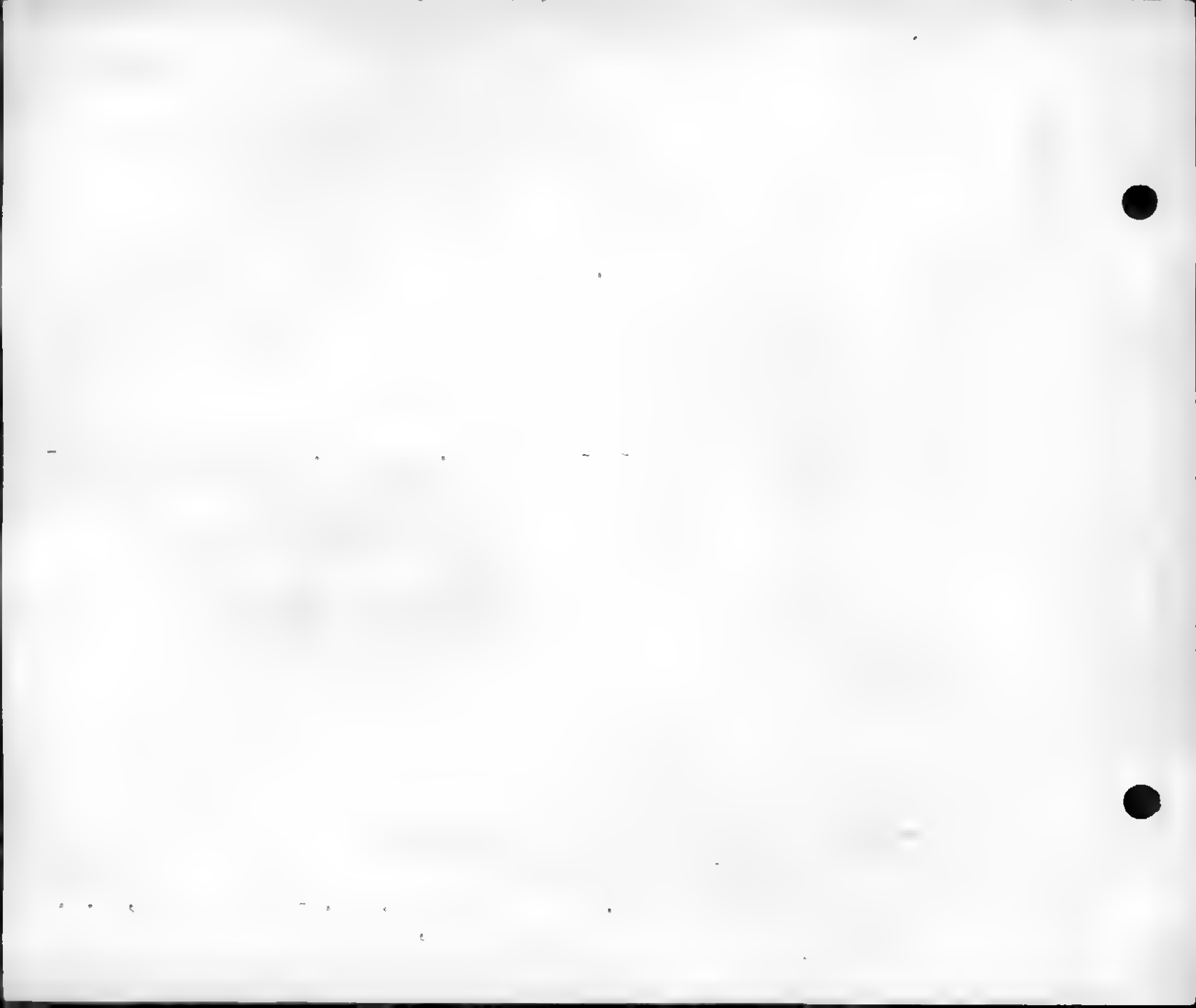
CERTIFICATE OF DEATH

15825

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>		c. LENGTH OF STAY IN TB <u>13 HRS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAGNOLIA GARDENS NURS. HOME</u>		d. STREET ADDRESS <u>4627 EASTERN AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT J. FREEMAN</u>		4. DATE OF DEATH Month Day Year <u>NOV. 19 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 14, 1922</u>
9. AGE (In years last birthday) <u>45</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Mason</u>		12. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
13. FATHER'S NAME <u>Leonard Freeman</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWII</u>		16. SOCIAL SECURITY NO <u>249-18-4695</u>	
17. INFORMANT Address <u>Mrs. Vivian C. Freeman (above ad-ress)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> 1939 DUE TO <u>Glioblastoma Multiforme</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> (c) <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8:00 PM</u> , 19 <u>67</u> , to <u>19 NOV</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>18 NOV</u> 19 <u>67</u> and that death occurred at <u>7:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Paul A. Devore</u> M.D.		22b. DATE SIGNED <u>19 NOV 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL A DEVORE MD</u>		22d. ADDRESS <u>3415 Hamilton St Hyattsville</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>11/22/67</u>	<u>Mt. View Baptist Ch. Cem. - Rutherford, N.C.</u>	
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR <u>DATE NOV 22 1967</u>	
ADDRESS <u>Mt. Rainier, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15832

15826

1. PLACE OF DEATH a. COUNTY <u>Pr. Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Laurel</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Laurel</u>			
c. LENGTH OF STAY IN 1b <u>9 years</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1510 10-15 Brooklyn Bridge Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				1510 10-15 Brooklyn Bridge Rd			
3. NAME OF DECEASED (Type or print) <u>CLAUDIUS Gail Furbee</u>				4. DATE OF DEATH <u>NOV 1 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 16 1891</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Furbee</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Jane Richards</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <u>5214</u>		17. INFORMANT <u>Donald Furbee Alexandria Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>9 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19__		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>9/2</u> 19 <u>67</u> to <u>11/1</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/1</u> 19 <u>67</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert S. McCeney</u>				22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT S. MCCENEY, M.D.</u>				22d. ADDRESS <u>402 MAIN ST.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem</u>		23d. LOCATION (City, town, or county) <u>Colman Manor, Md.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson, Laurel Md</u>				25a. REC'D BY REGISTRAR <u>NOV 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

47.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15833

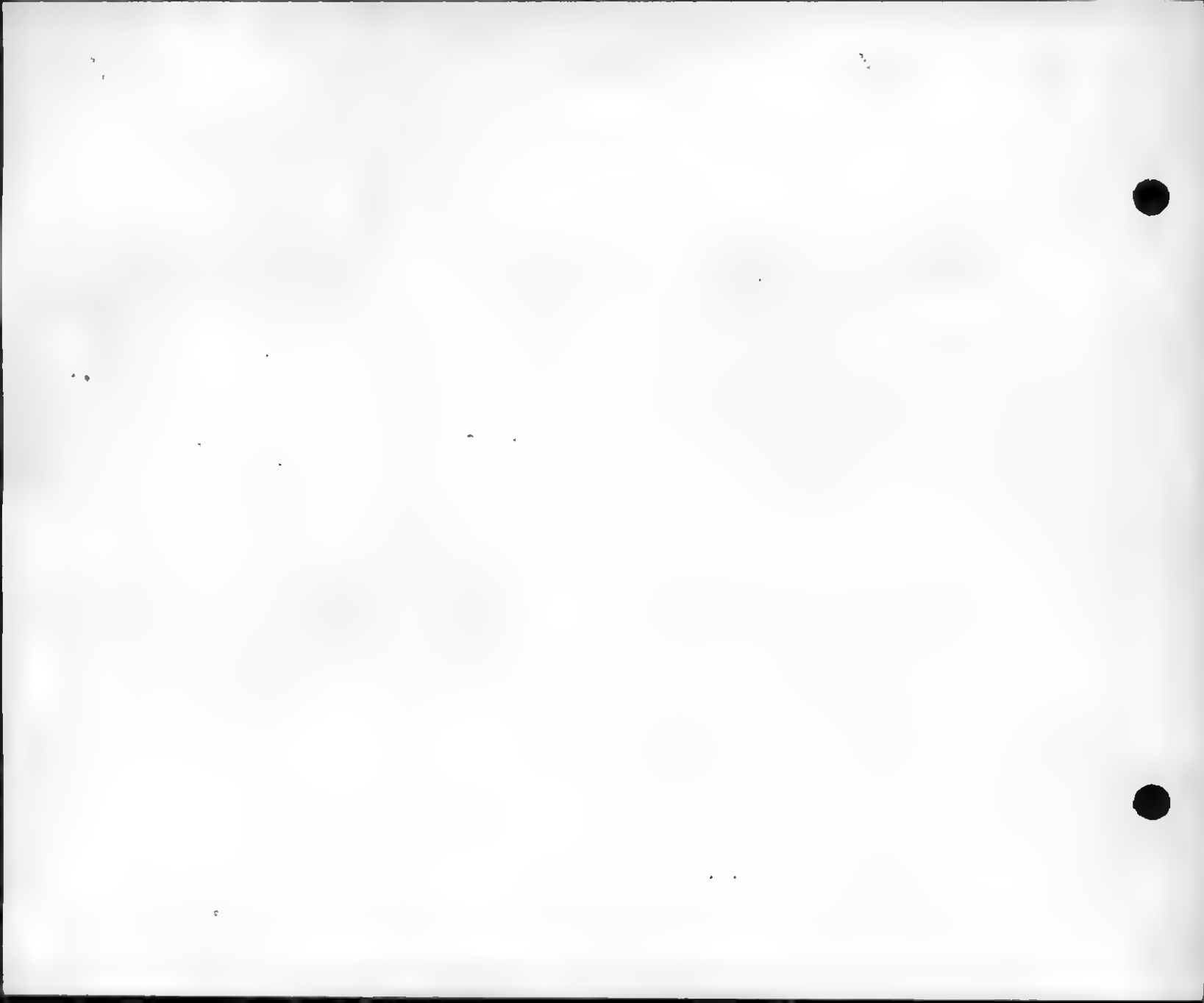
15827

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 7113. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4101 Brooks Drive</b>				d. STREET ADDRESS <b>4101 Brooks Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Carl Alegre Garcia</b>				4 DATE OF DEATH Month Day Year <b>11 2 1967</b>			
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11-4-10</b>		9 AGE (in years last birthday) <b>56</b> yrs	10 UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ACCOUNTANT</b>		10b KIND OF BUSINESS OR INDUSTRY <b>GEN. ACCT. U.S.</b>		11 BIRTHPLACE (State or foreign country) <b>PHILIPPINES</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>UNKNOWN</b>				14 MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES W.W. II</b>		16 SOCIAL SECURITY NO. <b>103 057782</b>		17 INFORMANT <b>MR. GORDON B. PRACHT</b>		Address <b>4795 HURON AV. SUITLAND, MD</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>+ 200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		Address (Street, city, town, or county)		22. DATE SIGNED <b>11-3-67</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>Nov 8 1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MD.</b>	
24 FUNERAL DIRECTOR <b>W.W. CHAMBERS, CO</b>		ADDRESS <b>60 RIVERDALE, MD</b>		25a REC'D BY REGISTRAR <b>NOV 7 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2M3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

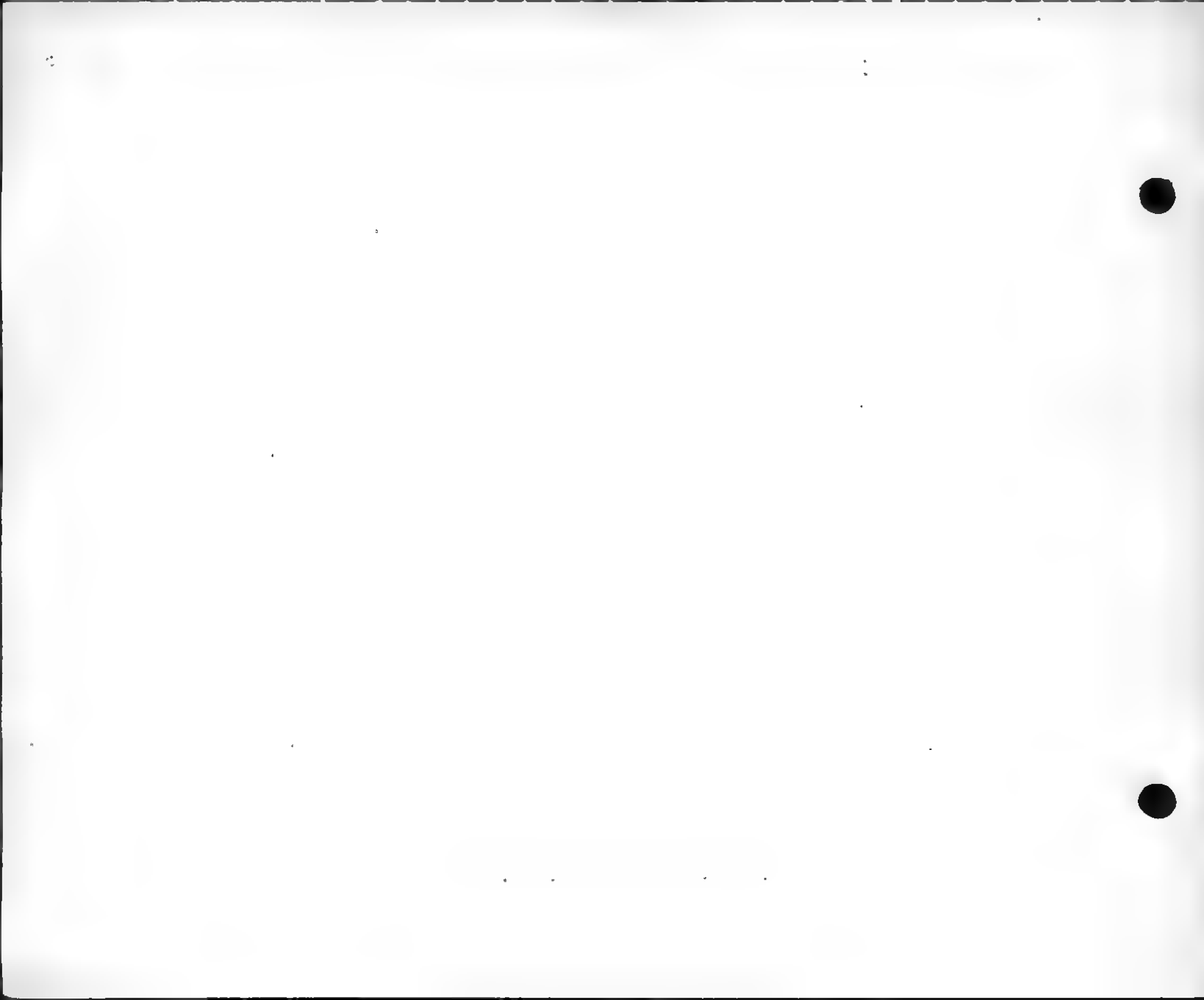
15834

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15828

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY in 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kentland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>2830 75th. Place</b>			
3. NAME OF DECEASED (Type or print) <b>Kenneth Lee Genthner</b>				4. DATE OF DEATH Month <b>11</b> Day <b>11</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-10-1949</b>	9. AGE (In years last birthday) <b>18</b> yrs.	IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington D C</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Erwin P Genthner</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy L. Smith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Erwin P Gunthner</b> Address <b>Kentland, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>774X</b> DUE TO <b>Hanging</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Hung self with trouser belt in jail</b>					
20c. TIME OF INJURY Month Day, Year Hour a.m. <b>11:50pm</b> <b>11-10-19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Cell, Prince George Co. Jail, Upper Marlboro.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b> <b>Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>11-13-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 14, 1967</b>		23c. NAME OF CEMETERY OR REPOSITORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH

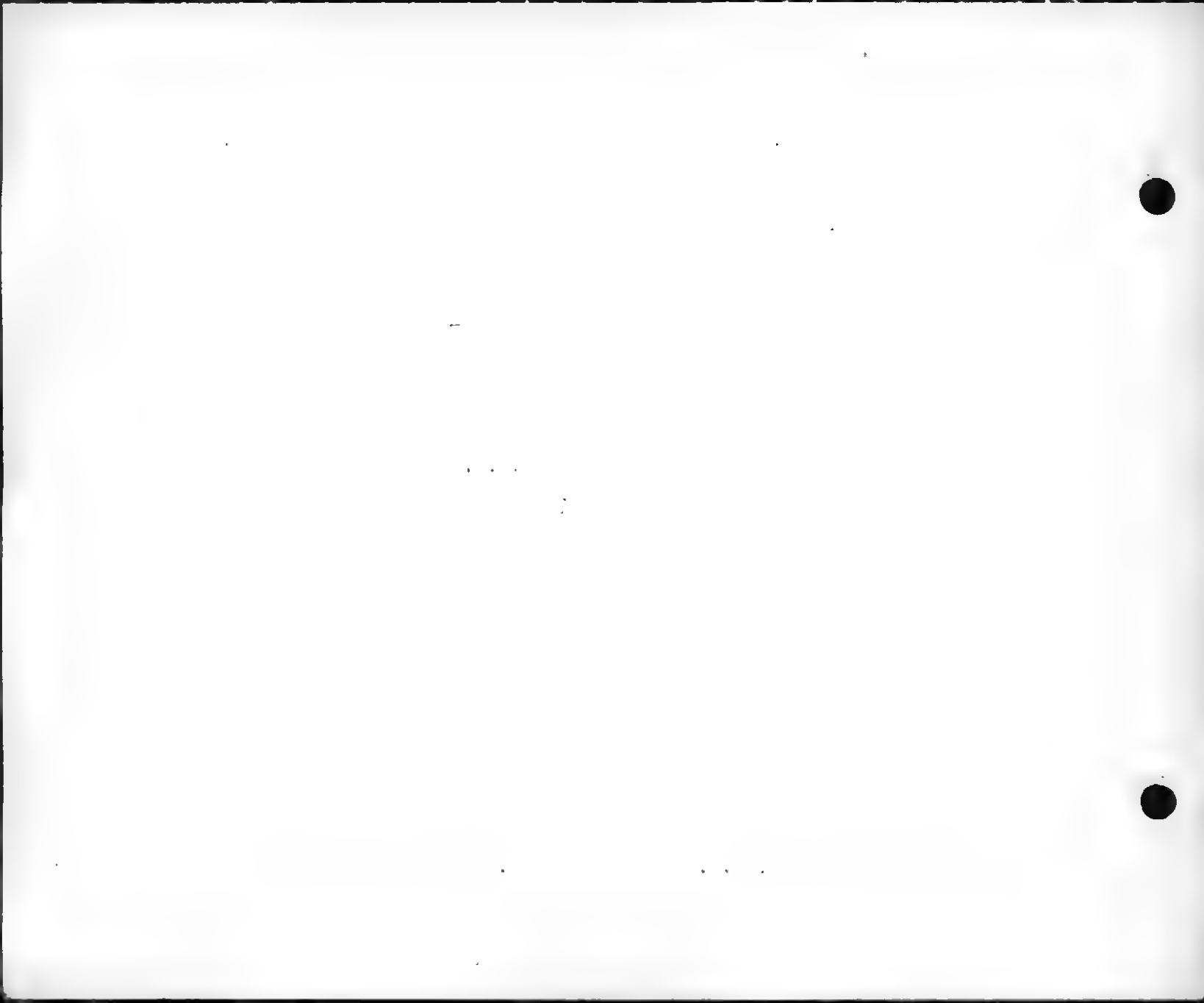
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15835

11440

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Unknown</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>Unknown</b>	
3 NAME OF DECEASED (Type or print) <b>Thaddeus Spencer Gibbs</b>		4 DATE OF DEATH <b>11 24 19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1-1-1915</b>
9 AGE (in years last birthday) <b>52</b> yrs		10 IF UNDER 1 YEAR <b>24</b> Months <b>19</b> Days <b>67</b> Hours <b>Min</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>F.B.I. Identification #716349B</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <b>5411</b> IMMEDIATE CAUSE (a) <b>Gastro intestinal hemorrhage</b> DUE TO <b>Perforating duodenal ulcer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED Where <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>11-26-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>12-6-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>University Hospital Anatomy Department</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland.</b>
24. FUNERAL DIRECTOR <b>Nalley Funeral Home Mt Rainier, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 7 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

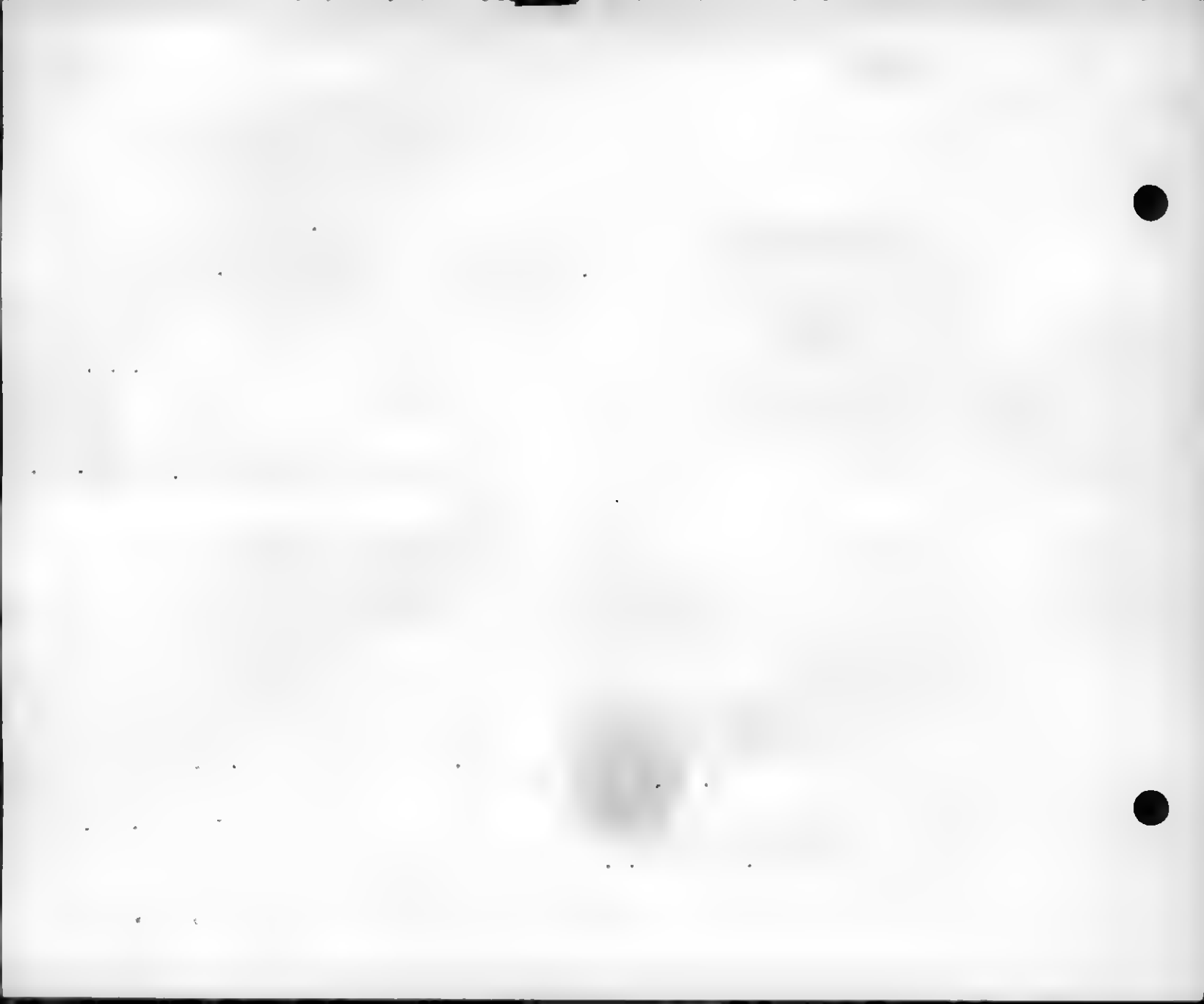
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15829

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>1+1/2 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>409 Lyndon Ave., Oak crest</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lester E. Gibson</b>				4 DATE OF DEATH Month Day Year <b>Nov. 27, 1967</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Colored</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3/30/18</b>	9 AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Ernest Gibson</b>				14. MOTHER'S MAIDEN NAME <b>Lavenia Mack</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Viola Gibson 118 Cissell Ave. Laurel, Md.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ruptured Berry aneurysm, Circle of Willis</b> DUE TO (c) <b>Bronchopneumonia, bilateral</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from <b>Nov. 26, 1967</b> , to <b>Nov. 27, 1967</b> , that (we) last saw the deceased alive on <b>Nov. 27, 1967</b> , and that death occurred at <b>3:50 P.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Arnold G. Brody</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. PM DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Nov. 28, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M.D.</b>				22d. ADDRESS <b>Prince Georges General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<b>Buried</b>		<b>12-1-67</b>		<b>Baltimore National,</b>		<b>Baltimore, Md.</b>	
24 FUNERAL DIRECTOR <i>George R. Snowden</i>				ADDRESS <b>Rock Hill</b>		25a. REC'D BY REGISTRAR <b>DEC 6 1967</b>	
						25b. REGISTRAR'S SIGNATURE <i>Charles J...</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15837

CERTIFICATE OF DEATH

15830

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. STREET ADDRESS <b>4709 Guilford Rd</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary C Gillis</b>		4. DATE OF DEATH Month Day Year <b>November 6 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/12/89</b>
9. AGE (In years last birthday) <b>78 7/8 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John C. Power</b>		14. MOTHER'S MAIDEN NAME <b>Murdoch Mary Mullican</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No -</b>		16. SOCIAL SECURITY NO. <b>579-10-6715</b>	
17. INFORMANT <b>Gillis, Murdock</b>		18. ADDRESS <b>4709 Guilford Rd College Park, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CA OF OVARY (RT.)</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b> <b>1 1/2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-31</b> , 19 <b>67</b> , to <b>11-6</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-6</b> , 19 <b>67</b> , and that death occurred at <b>3:15 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>C. J. Horne</b>		22b. DATE SIGNED <b>11-6-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/9/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Rockville, Md.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>NOV 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John L. Judge</b>			



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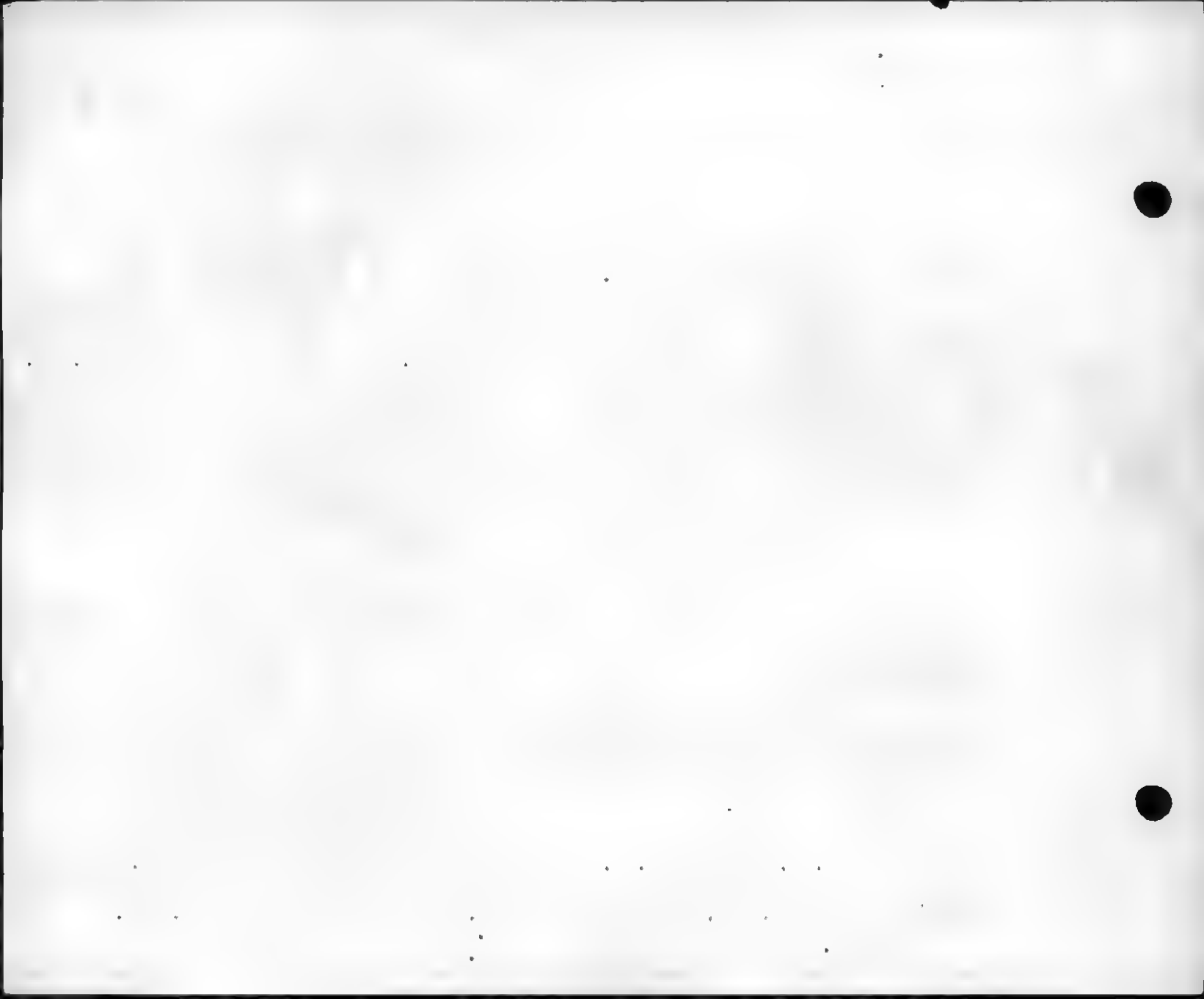
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

75831

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>1</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Ann Arundel</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessup</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>						d. STREET ADDRESS <b>Holiday Mobile Estates B-1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Hazel B. Glisan</b>			First Middle Last			4. DATE OF DEATH <b>November 15, 1967</b>			Month Day Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-11-98</b>		9. AGE (In years last birthday) <b>69</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Penn.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George William Baker</b>						14. MOTHER'S MAIDEN NAME <b>Enlow, Barbara</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>162-14-6945</b>		17. INFORMANT <b>Daughters/Medical Record</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTERCAPILLARY GLOMERULO SCLEROSIS</b> DUE TO (b) <b>DIABETES MELLITUS</b> DUE TO (c) <b>30 YR.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH <b>30 YR.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes on and on the date stated above.											
22a. SIGNATURE <b>J. R. Compton, M. D.</b>						22b. DATE SIGNED <b>15 NOV 67</b>			22c. PHYSICIAN'S NAME (Type) <b>J. R. Compton, M. D.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Nov. 18, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lafatte Mem. Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Briar Hill, Pa.</b>		
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm</b>						25a. REC'D BY REGISTRAR <b>NOV 20 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>		



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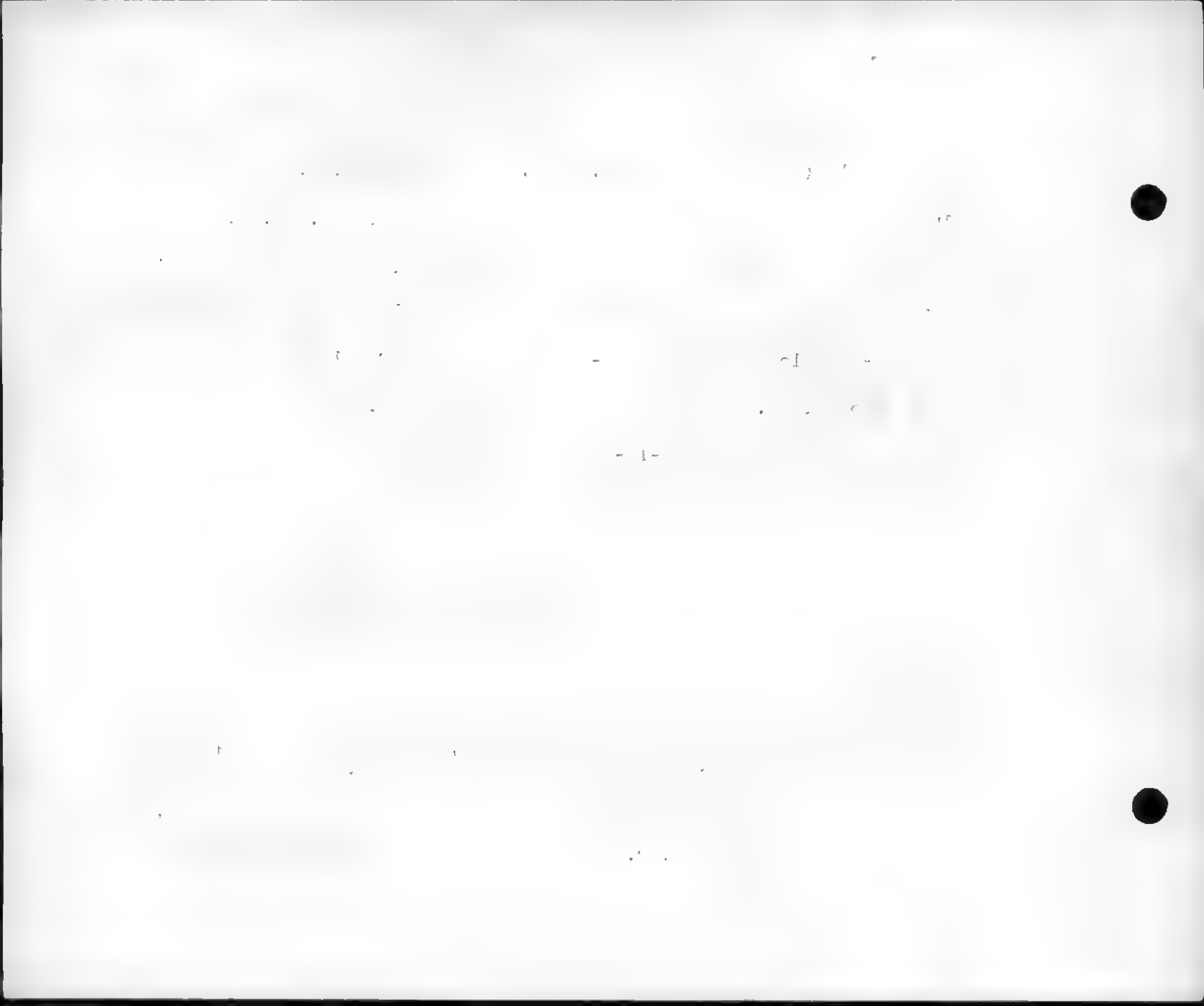
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

158339

CERTIFICATE OF DEATH

15832

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D. C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 7b <b>6mos., 2wks.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>129 Tenn. Ave., N. E.</b>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>--</b> Last <b>Glover, Jr.</b>		4. DATE OF DEATH Month <b>11</b> Day <b>1</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>5/24/1917</b>
9. AGE (In years last birthday) <b>50</b> yrs		IF UNDER 1 YEAR Months <b>11</b> Days <b>1</b> Hours <b>19</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown -unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>James Glover, Sr.</b>		14 MOTHER'S MAIDEN NAME <b>Rachael M. Smith</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>248-12-5369</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma of right lung with metastases</b> 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). <b>Pulmonary tuberculosis; diabetes mellitus; rheumatoid arthritis</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>4/17/1967</b> , to <b>11/1/1967</b> , that (X) (we) last saw the deceased alive on <b>11/1/1967</b> , and that death occurred at <b>9:45 AM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Moe Weiss</b> M.D.		22b DATE SIGNED <b>11/1/67</b>	
22c PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>	
23a BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL (Specify)	23b DATE THEREOF <b>NOV-7-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>HARMONY MEMORIAL</b>	23d LOCATION (City or Town) (County) (State) <b>7601-SHERIFF RD LANDOR-MD</b>
24. FUNERAL DIRECTOR <b>James T. Sutton</b>		25a. REC'D BY REGISTRAR <b>NOV 6 1967</b>	
ADDRESS <b>2718-12th N.E.</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





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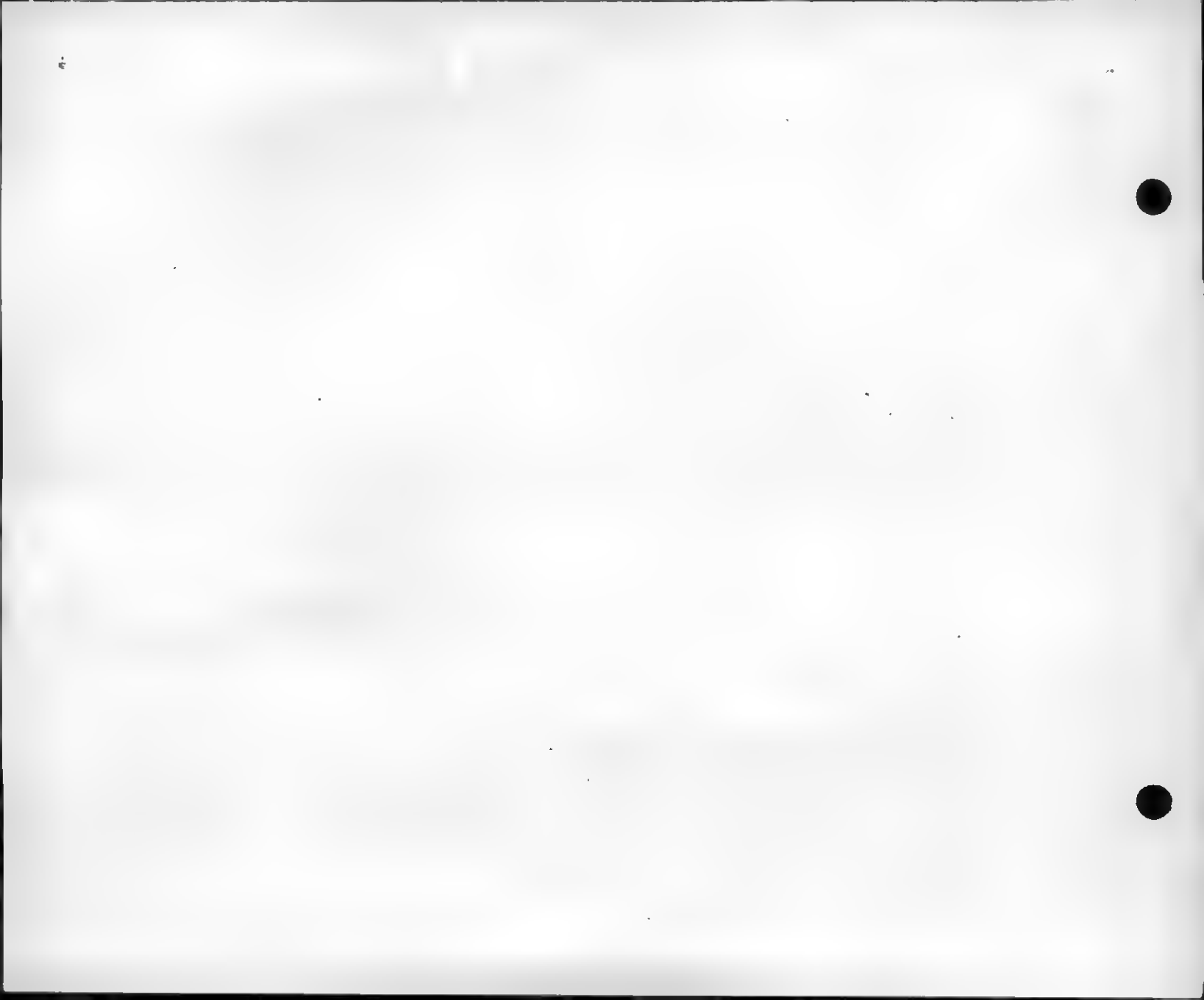
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15840

CERTIFICATE OF DEATH

15833

1. PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>DC.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville, Md.</u>		c. LENGTH OF STAY IN 1b <u>Washington, DC</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Rehabilitation Center</u>		d. STREET ADDRESS <u>944 Southern Ave. S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>N. Goldsmith</u> Last <u>N. Goldsmith</u>		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-1893</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beta-Guard D.C. Jail</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LA PLATA, Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Townley Goldsmith</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Welch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Rina B. Goldsmith - Same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>COMA</u> DUE TO <u>CEREBRAL HEMORRHAGE</u> (b) <u>THROMBOCYTOPENIA</u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>PANOCYTOPENIA, CEREBROVASCULAR INSUFFICIENCY CHRONIC OBSTRUCTIVE LUNG DISEASE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-18-1967</u> to <u>11-18-1967</u> that (I) (we) last saw the deceased alive on <u>11-17-1967</u> , and that death occurred at <u>10:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Oliver B. Bond</u>		22b. DATE SIGNED <u>11-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>OLIVER B. BOND MD</u>		22d. ADDRESS <u>6872 LIVERDALE ROAD LANHAM MARYLAND 20801</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-21-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>		25a. REC'D BY REGISTRAR <u>NOV 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>William A. Judge</u>		25c. REGISTRAR'S NAME <u>William A. Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15841

15834

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> 16			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box #369, Old Indianhead Road</u>				d. STREET ADDRESS <u>Box #369 Old Indianhead Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>I.</u> Last <u>Gray</u>				4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-31</u>	9. AGE (In years last birthday) <u>36</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Prince Geo's. Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas Francis Gray</u>				14. MOTHER'S MAIDEN NAME <u>Rosetta Edelin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>214-28-8814</u>		17. INFORMANT <u>Maggie Gray</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>shot by assailant</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>1:50pm</u> <u>11-4</u> 19 <u>67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, off ce, bldg, etc.) <u>driveway of home</u>		20f. (City or town) <u>Brandywine</u>	(County) <u>P.G.</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John Kehoe M.D., Riverdale, Maryland</u>		Address (Street, city, town, or county)		22. DATE SIGNED <u>11-6-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)			
<u>Burial</u>	<u>11-9-67</u>	<u>Church of God Cem.</u>		<u>Brandywine Prince Geo's Co. Md</u>			
24. FUNERAL DIRECTOR <u>Martell Adams Aquasco, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

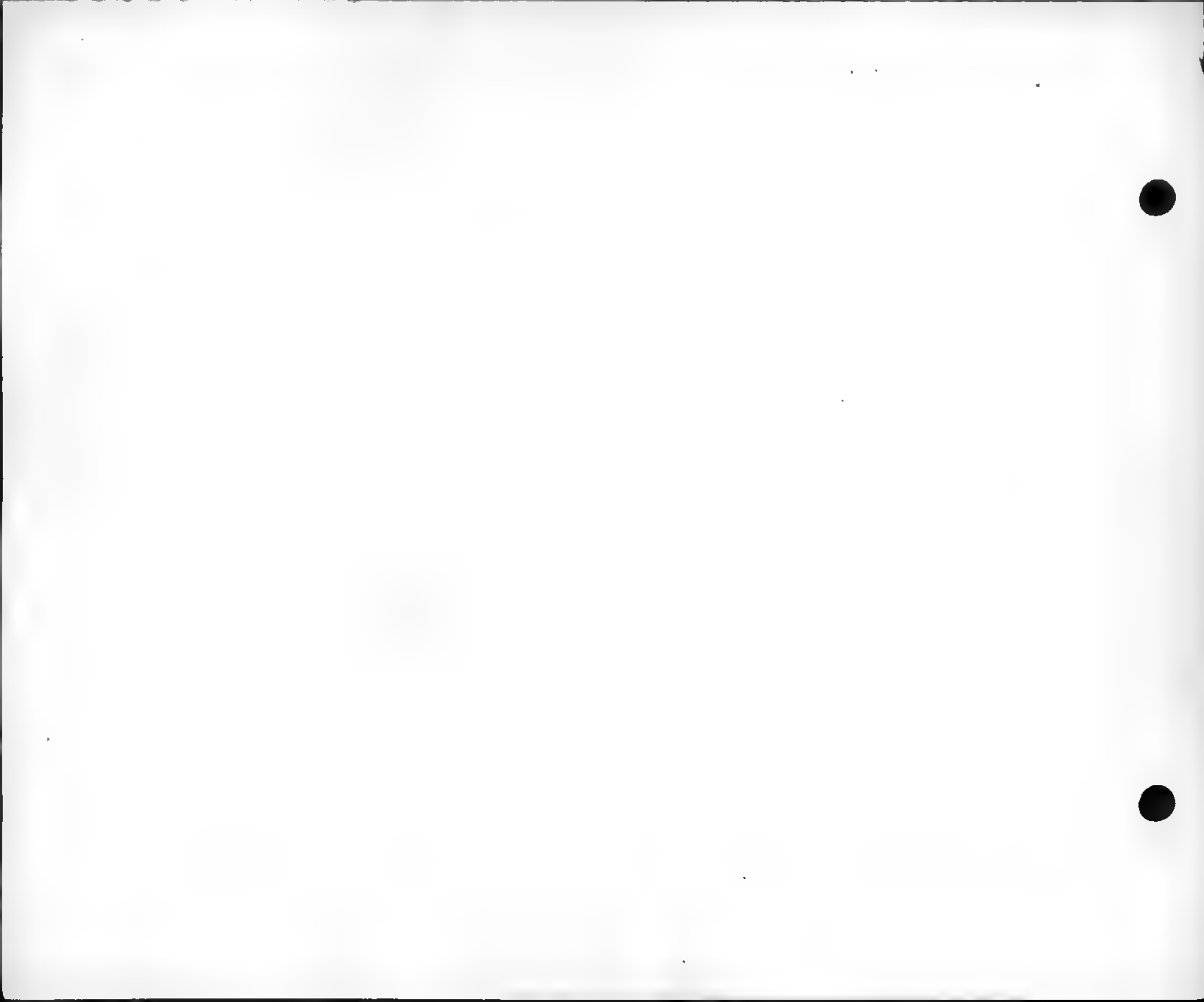
FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film G395 11/21/67 KK

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deanwood Park</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>1302 51st Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Naomi E. Greenleaf</u>				4. DATE OF DEATH Month Day Year <u>11 10 19 67</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-18</u>		9. AGE (In years last birthday) <u>49 19</u> yrs	IF UNDER 1 YEAR Months Days Hours Min <u>11 10 19 67</u>	
10a. USUAL OCC. PAT. ON (Give kind of work done during last of work week, even if retired) <u>Beautyician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beauty Shop</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Boswell Yates</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Gibson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edith Barber - neice</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> <u>921X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 18) <u>shot during altercation</u>					
20c. TIME OF INJURY Month, Day Year Hour am p.m. <u>8:25 a.m. 11-10 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>KITCHEN of home</u>		20f. (City or town) (County) (State) <u>Deanwood Park, P.G. Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe M.D.</u> EXAMINER'S NAME (Type) <u>John Kehoe M.D., Riverdale, Maryland</u>				22. DATE SIGNED <u>11-11-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11-14-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nat. Harmony</u>		23d. LOCATION (City or Town) (County) (State) <u>Highland Park 14th</u>	
24. FUNERAL DIRECTOR <u>H.S. WASHINGTON &amp; SONS INC.</u> ADDRESS <u>4925 Deane Ave. N.E. WASH., D.C.</u>				25a. REC'D BY REGISTRAR <u>NOV 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15843

15836

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived; if institut on Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton, Md.</u>		c. LENGTH OF STAY in 1b <u>7 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens Health Center</u>		d. STREET ADDRESS <u>1021 Broadview Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>Griffin</u> Last		4 DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-5-98</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARDNER</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Handyman</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Felix Griffin</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>519-10-2197</u>	
17. INFORMANT <u>William Allen</u> Address <u>1601 - 8th St NW Washington</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> 1051 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinomatous</u> DUE TO (c) <u>Carcinoma of lungs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home farm factory, street, office bldg etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-26</u> , 1967, to <u>11-14</u> , 1967, that (I) (we) last saw the deceased alive on <u>11-14</u> , 1967, and that death occurred at <u>8:50 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Alfred R. Lapin</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>		22d. ADDRESS <u>CLINTON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ocean Hill Md. Ocean Hill Md.</u>	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR <u>Brown &amp; Daugherty</u>		25a. REC'D BY REGISTRAR <u>Nov 20 1967</u>	25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>





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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15-37

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>R.R. Box 2250</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary W. Griffith</b>			4. DATE OF DEATH Month Day Year <b>Nov. 9, 1967</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/24/19</b>	9. AGE (In years last birthday) <b>48 yrs</b>	10. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Prince George Co. Md.</b>			
13. FATHER'S NAME <b>James G. Proctor</b>			14. MOTHER'S MAIDEN NAME <b>Cora Swann</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>William L. Griffith</b> Address <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>5810</b> <b>= Cirrhosis of Liver, severe</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Infarction and Hemorrhage of cerebrum and Cerebellum</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)			
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Nov. 9, 1967</b> , to <b>Nov. 9, 1967</b> , that (I) <del>(the hospital)</del> last saw the deceased alive on <b>Nov. 9, 1967</b> , and that death occurred at <b>9:45 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>A. Clark Holmes</b>			22b. DATE SIGNED <b>11/10/67</b>		22c. PHYSICIAN'S NAME (Type) <b>A. Clark Holmes, M. D.</b>		
23a. BURIAL, CREMATION, REMOVAL (City) <b>Burial</b>			23b. DATE THEREOF <b>11-13-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cem.</b>		
24. FUNERAL DIRECTOR <b>Marrell Adams Aquasas, Md.</b>			23d. LOCATION (City or town) (County) (State) <b>Clinton, Pr. Geo. Co. Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>		
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

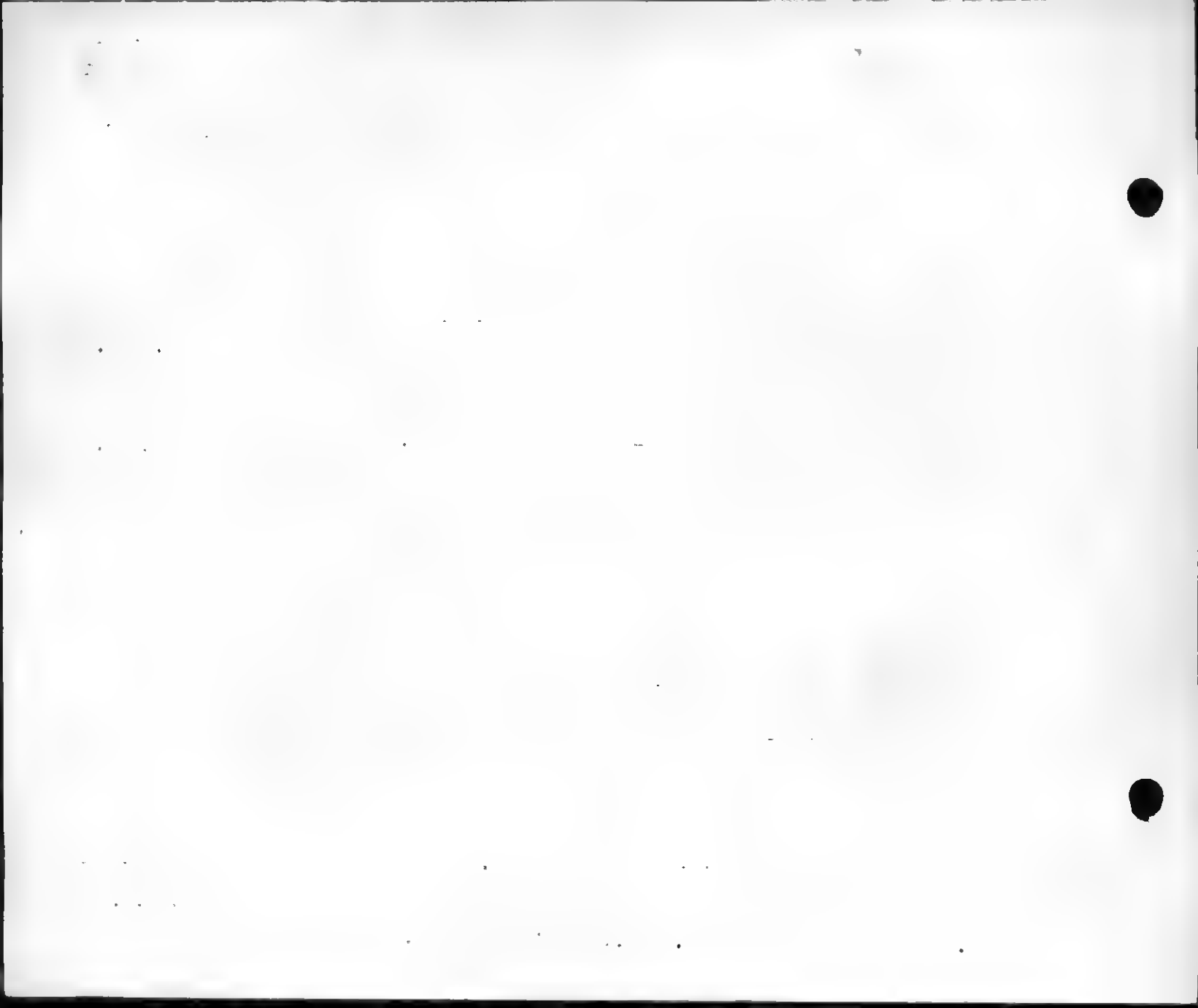
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

15845

15838

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>33 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				d. STREET ADDRESS <b>8312 Fremont Street</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>Wilhelmina Guenthner</b>				4 DATE OF DEATH Month <b>11</b> Day <b>14</b> Year <b>19 67</b>			
5 SEX <b>Female</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>11-16-1882</b>	
9 AGE (In years last birthday) <b>84</b> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11 BIRTHPLACE (State or foreign country) <b>South Dakota</b>	
12 CITIZEN OF WHAT <b>U.S.A.</b>		13 FATHER'S NAME <b>Joseph Klauert</b>		14 MOTHER'S MAIDEN NAME <b>Magdalena Welk</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO. <b>215-48-2188-T</b>		17 INFORMANT <b>Rupert W. Guenthner</b>		18a ADDRESS <b>3242 North Columbus Arlington, Va.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>42</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____	
19 INTERVAL BETWEEN ONSET AND DEATH <b>over 2 yrs.</b>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of the right hip - 33 days</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fell at home</b>		20c TIME OF INJURY Month, Day Year Hour a.m. _____ <b>3:40 p.m. 10-12- 19 67</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f (City or town) <b>same as #2</b>		20g (County) <b>same as #2</b>		20h (State) <b>same as #2</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <b>11-15-67</b>		ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b DATE THEREOF <b>11/18/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Bridgewater Cemetery</b>		23d LOCATION (City or town) <b>Bridgewater, S.D.</b>		23e (County) <b>S.D.</b>	
23f (State) <b>S.D.</b>		24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		25a ADDRESS <b>4739 Balt. Ave., Hyattsville, Md.</b>		25b REC'D BY REGISTRAR <b>NOV 20 1967</b>	
25c REGISTRAR'S SIGNATURE <b>William J. Jones</b>		25d (City or town) <b>Hyattsville, Md.</b>		25e (County) <b>Prince George's</b>		25f (State) <b>Md.</b>	



1  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 25M 11/67

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

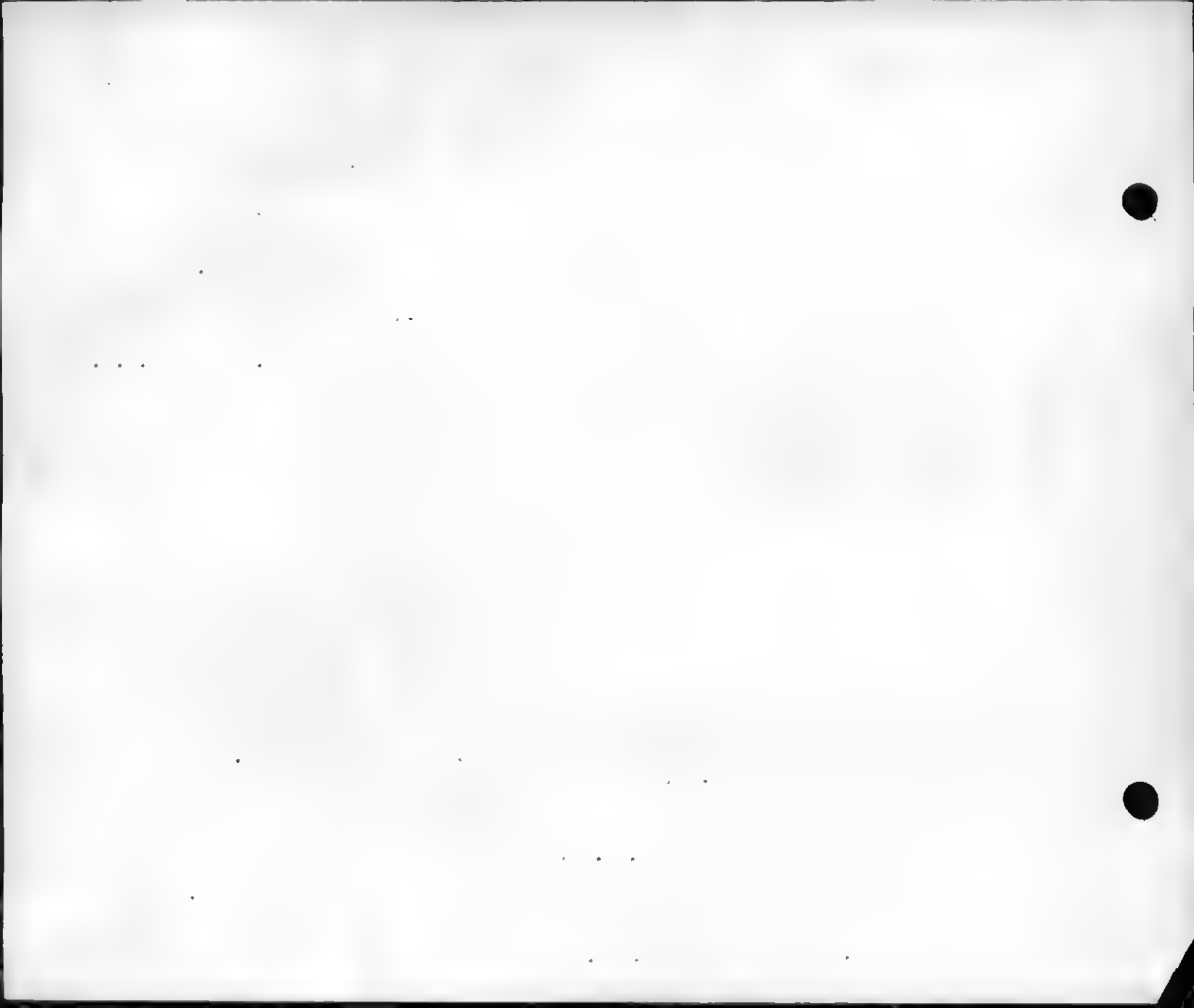
CERTIFICATE OF DEATH

15846

11839

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN TB <b>2 hrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>5007 Holly Spring Rd</b>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Girl</b> Last <b>Hall</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 Nov., 1967</b>
9. AGE (In years lost birthday) yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Prince Georges Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <b>Marie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atelectasis of lungs. bilateral.</u> DUE TO (c) <u>Cephalhematoma.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>(s)</del> (this hospital) attended the deceased from <u>Nov. 6,</u> 19 <u>67</u> , to <u>Nov. 6,</u> 19 <u>67</u> , that <del>(s)</del> (we) lost <del>saw</del> the deceased alive on <u>Nov. 6,</u> 19 <u>67</u> , and that death occurred at <u>4:15 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Bernardo Alvarado, M. D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11-11-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General</b>	23d. LOCATION (City or town) (County) (State) <b>Cheverly, Md.</b>
24. FUNERAL DIRECTOR <b>William A. Parker, Cheverly, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 14 1967</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

7-269101



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

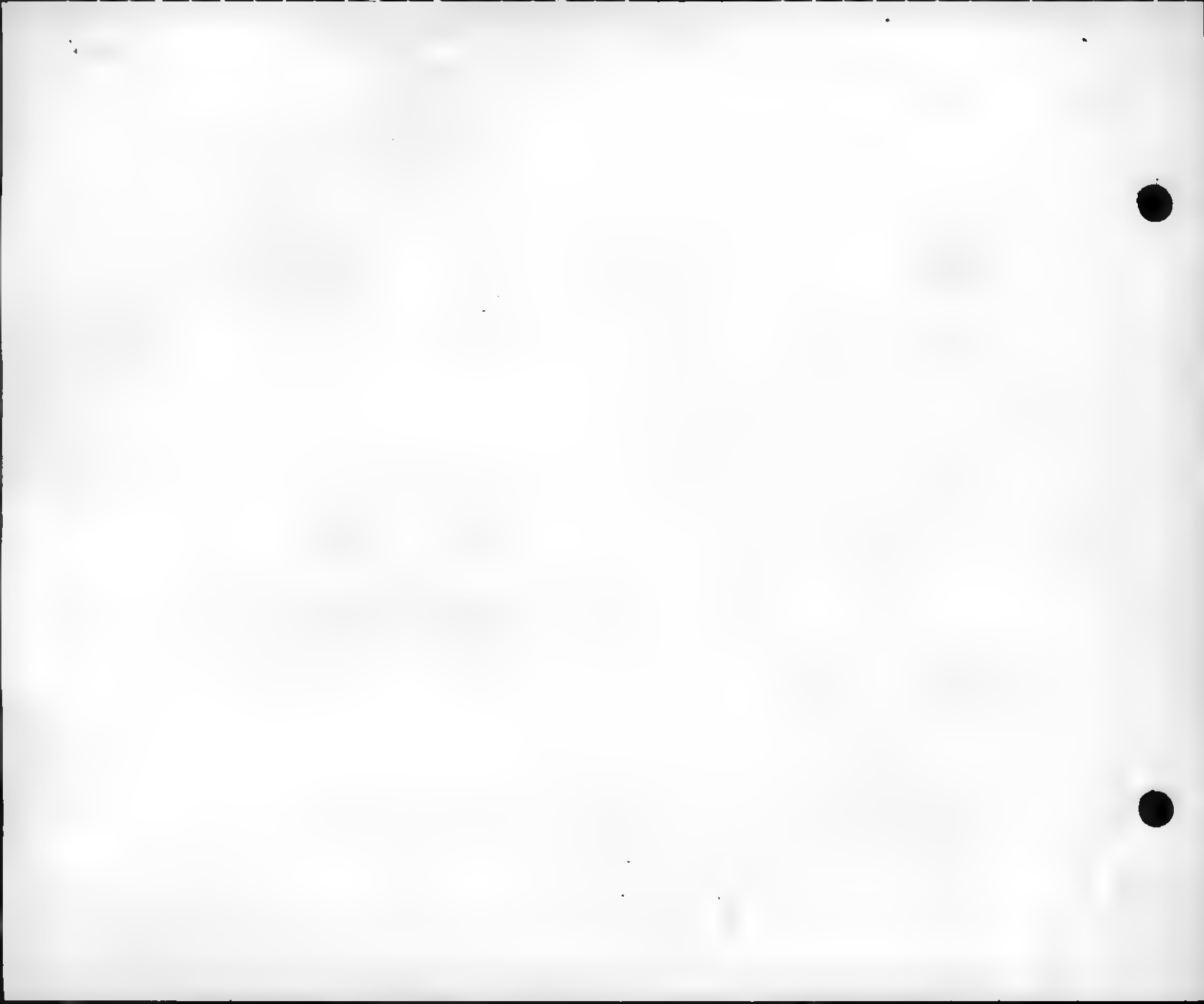
15841

15840

1. PLACE OF DEATH a. COUNTY <u>P. Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b <u>2 wks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens Health Care Center</u>		d. STREET ADDRESS <u>1401 Strauss Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>JULIA</u> Middle <u>S.</u> Last <u>HALLA</u>		4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 12 1888</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
11. BIRTHPLACE (County & State or foreign country) <u>(Annesian) Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>H. Temple Stevens Med</u>		14. MOTHER'S MAIDEN NAME <u>Betty Hughes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>212-16-4090-1</u>	
17. INFORMANT <u>Mrs. Margaret James</u>		18. ADDRESS <u>RED 13th H311 Upper Marlboro, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular arterial disease</u> DUE TO (c) <u>Senile Degeneration</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-10</u> , 19 <u>67</u> , to <u>11-23</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11-23</u> , 19 <u>67</u> , and that death occurred at <u>5:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin</u> M.D.		22b. DATE SIGNED <u>11-23-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>		22d. ADDRESS <u>CLINTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 26, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Potomac Baptist</u>	23d. LOCATION (City or Town) (County) (State) <u>Camorn King Geo. Va.</u>
24. FUNERAL DIRECTOR <u>X Hunt Funeral Home, Waldorf Md</u>		25a. REC'D BY REGISTRAR <u>James Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 28 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

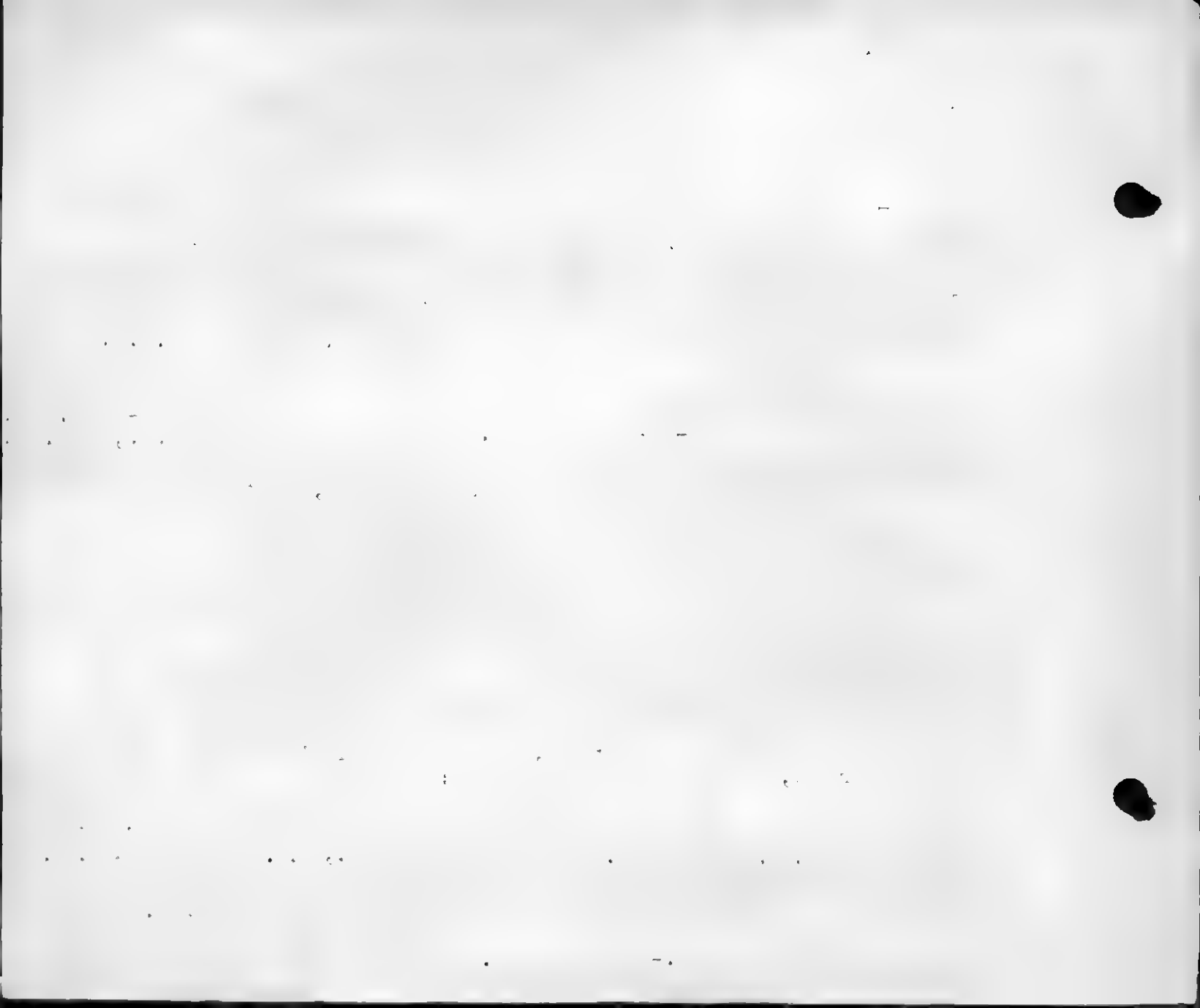
## CERTIFICATE OF DEATH

15841

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges County</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>			c. LENGTH OF STAY IN 1b <u>3 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanjemoy (Rural)</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence - 4653 Tamar Avenue</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Inez</u> Middle <u>Virginia</u> Last <u>HANCOCK</u>				<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>12</u> Year <u>1967</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>December 5, 1886</u>	
<b>9. AGE</b> (In years last birthday) <u>80</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		<b>IF UNDER 24 HRS.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>King George, Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>John Henry Carpenter</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Nanny Burchill</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>212-54-0339</u>		<b>17. INFORMANT</b> Address <u>1411 - 19th. St. S.E., Wash., D.C.</u> <u>B Mrs. Vesta Holt-Daughter</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Cerebral (Arteriosclerosis) Hemorrhage, right side</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>  </u>							<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>One month</u>  <u>Two years</u>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>a. m.</u> <u>  </u> p. m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>August 28, 1967</u> , <b>to</b> <u>November 11, 1967</u> , <b>that I last saw the deceased alive on</b> <u>November 11, 1967</u> , <b>and that death occurred at</b> <u>6:30 A.M.</u> , <b>from the causes and on the date stated above.</b>							
<b>ACTUAL SIGNATURE</b> <u>William J. P. Howard</u> M.D.				<b>ADDRESS</b> (Street, city or town, state) <u>1331 Staples St., N.E. Washington, D.C.</u> <b>DATE SIGNED</b> <u>Nov. 12, 1967</u>			
<b>PHYSICIAN'S NAME (Type)</b> <u>William J. P. Howard, M.D.</u>				<u>1331 Staples St., N.E. Washington, D.C.</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11/14/1967</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Nanjemoy Baptist Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Nanjemoy, Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arehart Funeral Home, Inc. - La Plata, Md.</u> ADDRESS				<b>24a. REC'D BY REGISTRAR</b> <u>NOV 15 1967</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15848

15842

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>17 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>5610 Shadyside Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nettie B. Hardy</b>		4. DATE OF DEATH Month Day Year <b>November 13 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/7/91</b>
9. AGE (In years last birthday) <b>76</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Benjamin Hardy</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Cora Ferreola 3627 Silver Pk, Dr. Suitland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Embolism</b> DUE TO (b) <b>Arterio Sclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sub capsule for R heart</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>this hospital</del> attended the deceased from <b>10-28</b> , 19 <b>67</b> , to <b>11/13</b> , 19 <b>67</b> , that (I) <del>was</del> last saw the deceased alive on <b>11/13</b> 19 <b>67</b> , and that death occurred at <b>3:16 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Francis D. Fowler</b> M.D.		22b. DATE SIGNED <b>P.M.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Francis D. Fowler, M. D.</b>		22d. ADDRESS <b>4400 Stamp Rd. Marlow Hgts, Maryland</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/17/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Church Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Forestville, Maryland PG</b>
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b>		25a. REC'D BY REGISTRAR <b>NOV 20 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
4308 Suitland Road, Suitland, Maryland			



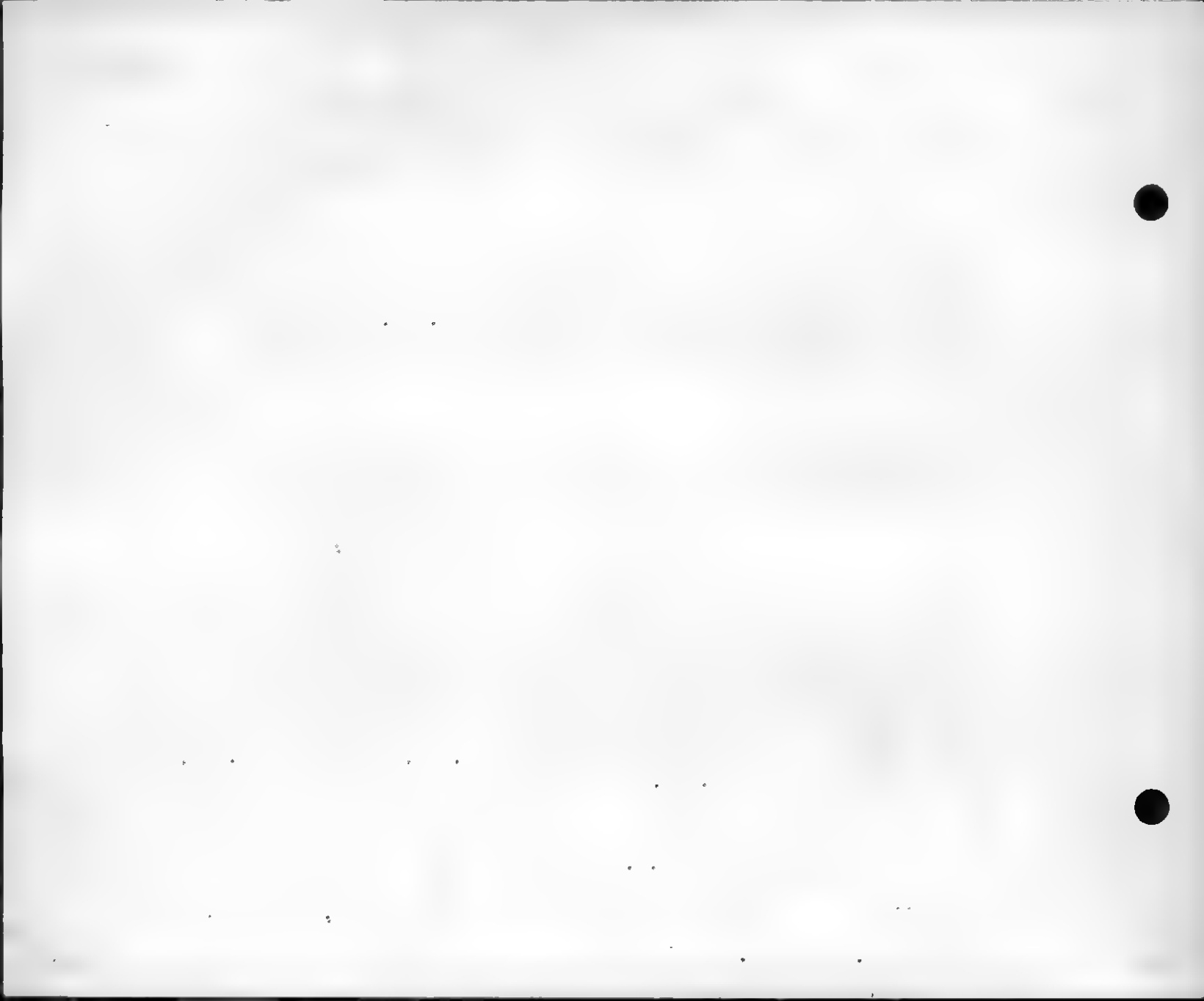
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

17501

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>2 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capitol Heights</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>6188 Rollins Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <i>Eugene</i> Middle <i>Charles</i> Last <i>Harper</i> <b>Baby Boy</b>				<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>18</b> Year <b>19 67</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Nov. 16, 1967</b>	<b>9. AGE</b> (In years lost birthday) yrs <b>2</b>	<b>10. UNDER 1 YEAR</b> Months <b>2</b> Days <b>2</b>	<b>11. UNDER 24 HRS</b> Hours <b>2</b> Min <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Distress syndrome;</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Edema with congestion;</b> DUE TO (c) <b>Cerebral edema;</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (X) (this hospital) attended the deceased from <u>Nov. 16, 1967</u>, to <u>Nov. 18, 1967</u>, that (X) (we) last saw the deceased alive on <u>Nov. 18, 1967</u>, and that death occurred at <u>12:45 M</u>, from causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>Edwin Jensen</i> M.D.				<b>ATTENDING PHYS</b> <input type="checkbox"/> <b>MED. AM DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS</b> <input checked="" type="checkbox"/>	<b>22b. DATE SIGNED</b> <u>Nov 24, 1967</u>		
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Edwin Jensen, M.D.</b>				<b>22d. ADDRESS</b> <b>Prince Georges General Hospital</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b>	<b>23b. DATE THEREOF</b> <b>12-9-67</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Prince George's General Hosp. Cheverly, Maryland</b>		<b>23d. LOCATION (City or Town)</b> (County) (State)			
<b>24. FUNERAL DIRECTOR</b> <i>W. Penn, Jr.</i> Administrator				<b>25a. REC'D BY REGISTRAR</b> <b>DEC 18 1967</b>	<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

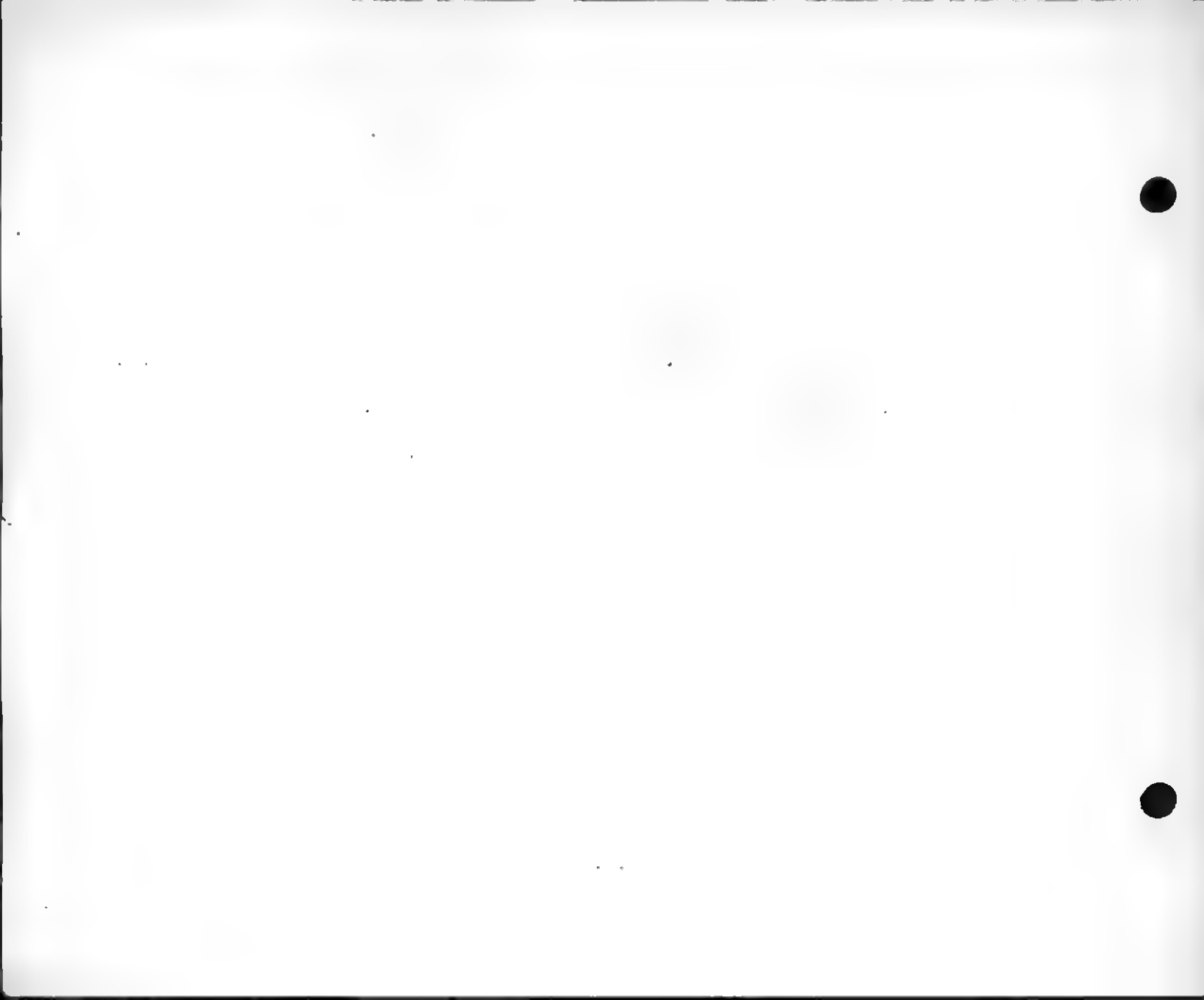
15851

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>9322 Fontana Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Frank Carlos Harper</b>		4. DATE OF DEATH <b>11 7 19 67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 March 1926</b>
9. AGE (in years last birthday) <b>41 yrs</b>		10. F UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Gale M. Harper</b>		14. MOTHER'S MAIDEN NAME <b>Carnie O. Evans</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW 11</b>		16. SOCIAL SECURITY NO <b>577 32 7731</b>	
17. INFORMANT <b>Daphne R. Harper Same as #2 (wife)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4200</b> IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>11-7-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D., Riverdale</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Buried</b>	23b. DATE THEREOF <b>11/7/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	23d. LOCATION (City or town) (County) (State) <b>Colmar Manor P.G. Md.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 9 1967</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

15852

1750

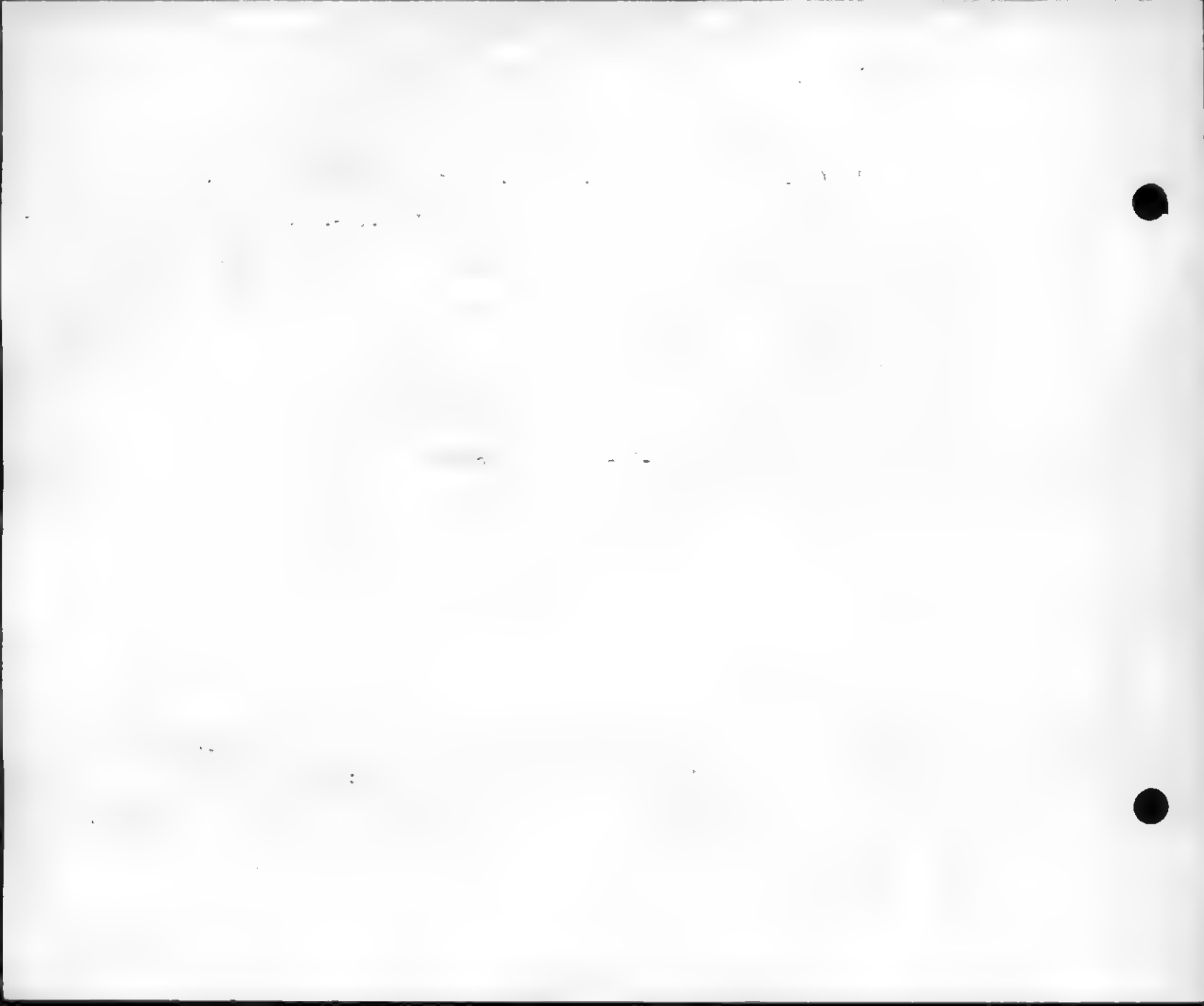
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**\*\*Also known as Mary Alice Plunkett**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY in 1b <b>2 mos., 3 wks.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ex Washington, D. C.</b>		d. STREET ADDRESS <b>50 N St., N. W.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alice -- Harris</b>		4. DATE OF DEATH Month Day Year <b>11 29 19 67</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>■</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/10/1908</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Parker</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Green</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>579-14-8998</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>445X</b> DUE TO <b>Recurrent cerebrovascular accidents with left hemiplegia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <b>Hypertensive and arteriosclerotic cardiovascular disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		INTERVA. BETWEEN ONSET AND DEATH <b>8 days</b> <b>years</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>9/6/</b> , 19 <b>67</b> , to <b>11/29</b> , 19 <b>67</b> , that <del>he</del> (we) last saw the deceased alive on <b>11/29/</b> 19 <b>67</b> , and that death occurred at <b>11:30AM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>11/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>	
23a. B. RIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>12-1-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Harmony mem. park</b>	23d. LOCATION (City or Town) (County) (State) <b>Landover Maryland</b>
24. FUNERAL DIRECTOR <b>Universal Funeral Home</b> <b>Washington D.C.</b>		25a. REC'D BY REGISTRAR <b>DEC 11 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

VR A15 41  
25M 1/67



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO BURIAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15853

15344

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover Hills</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>4817 Rockford Drive</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert P. Harris</b>		4. DATE OF DEATH Month Day Year <b>11 2 19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-30-59</b>
9. AGE (In years last birthday) <b>8</b>		10. IF UNDER 1 YEAR Months Days Hours Mm	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Robert P. Harris sr</b>		14. MOTHER'S MAIDEN NAME <b>Shirley A Baldwin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Robert P Harris Sr</b>		Address <b>Landover Hills, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Contusion and Laceration of brain</b> <b>1040</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Skull Fracture</b> DUE TO (c) <b>Trauma</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple Pulmonary Emboli</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>fell at home</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>P.M. 10-28 19 67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>
20f. (City or town) <b>Landover,</b>		(County) <b>P.G.</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe M.D., Riverdale, Maryland</b>		22. DATE SIGNED <b>11-3-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		Address (Street, city, town, or county) <b>Landover Hills, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 4, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>NOV 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 9 film 8195 12/12/67 KK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George's</u>			
b CITY OR TOWN (If outside corporate m'ts, write RURAL and give nearest town) <u>Cheverly</u>				c LENGTH OF STAY IN 1b <u>DOA</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>C</u> Last <u>Harris</u>				4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 Sept. 1942</u>	9. AGE (In years last birthday) <u>25</u> yrs	F UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Burner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John F. Harris</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Swager</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>287-36-2088</u>		17. INFORMANT <u>Betty Ann Harris</u> Address <u>733 Sherman Ave. Sharon, Pa.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <u>784 x</u> IMMEDIATE CAUSE (a) <u>Gun shot wound of back</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Shot by police during armed robbery.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>11-26-1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Chillum Rd. &amp; Sargent Rd., Hyattsville, Md.</u>		20f. (City or town) (County) (State) <u>Hyattsville, Md.</u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u>		EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>11-27-67</u>	
23a. BURIAL, CREMATION, REMOVAL, or other disposition <u>Removal</u>		23b. DATE THEREOF <u>Nov 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Giroski Funeral Home</u>		23d. LOCATION (City or Town) (County) (State) <u>Farrell Pa.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 1 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

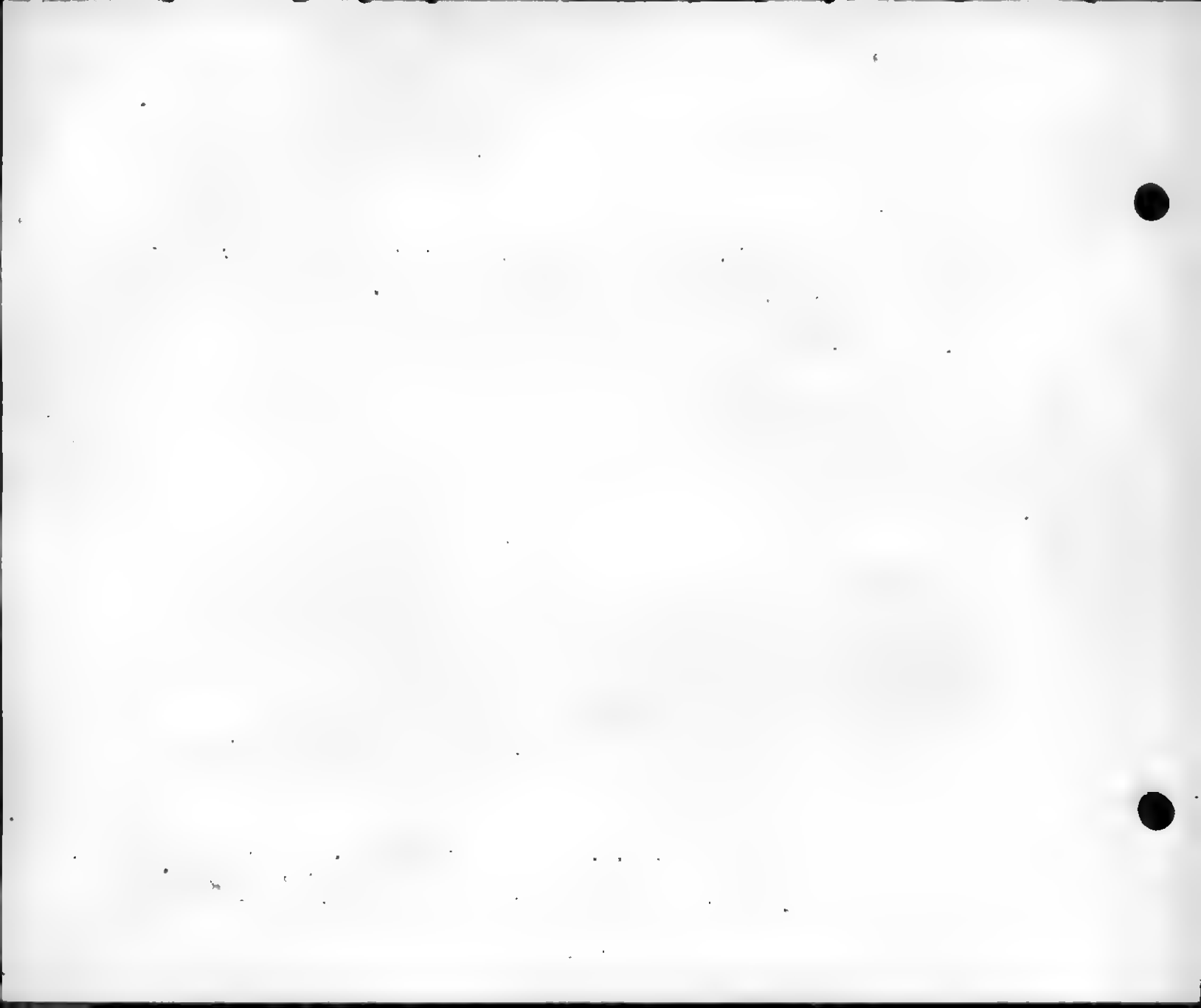


TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15955  
17046  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GREENBELT</b> c. LENGTH OF STAY IN ID <b>GREENBELT</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>9102 EDMONSTON CT.</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GREENBELT</b> d. STREET ADDRESS <b>9102 EDMONSTON CT</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>LOUISE PARTRIDGE HARRON</b>			4. DATE OF DEATH Month Day Year <b>NOV 24 1967</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>SEPT 17, 1917</b>		9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>PENN'A</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>			13. FATHER'S NAME <b>HILBERT SIDLER</b>		
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>UNKNOWN</b>			17. INFORMANT <b>CLARENCE M. HARRON</b> Address <b>SAME AS #2.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>generalized carcinoma</b> DUE TO (b) <b>carcinoma of colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>9. week</b>
MEDICAL CERTIFICATION					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (i) (this hospital) attended the deceased from <b>Oct 30</b> , 1967, to <b>Nov 24</b> , 1967, that (i) (we) last saw the deceased alive on <b>Nov 24</b> , 1967, and that death occurred at <b>2:40</b> A.M. from the causes and on the date stated above.					
22a. SIGNATURE <b>Till Bergemann</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-24-1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Till Bergemann, M.D.</b>		22d. ADDRESS <b>Greenbelt Professional Building</b> <b>Greenbelt, Maryland 20770</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-28-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SCHUYLKILL MEM CEM</b>	
23d. LOCATION (City, town or county) <b>GREENBELT, PENN'A.</b>		(State)			
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS</b>		ADDRESS <b>COO RIVERDALE, MD.</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>W. W. Chambers, Cnd. 90.</b>					





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <b>Prince George</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>California</b> b COUNTY <b>2</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c LENGTH OF STAY IN 1b <b>22 days</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d STREET ADDRESS <b>1204 Winston Court</b>	
3 NAME OF DECEASED (Type or print) First <b>Warren</b> Middle <b>Glen</b> Last <b>Hendricks</b>		4. DATE OF DEATH Month <b>11</b> Day <b>5</b> Year <b>19 67</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 24 1947</b>
9 AGE (In years lost birthday) yrs. <b>20</b>		10 IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>67</b> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		10b KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>	
11 BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <b>Warren Glen Hendricks Sr.</b>		14 MOTHER'S MAIDEN NAME <b>Lorraine June (Unknown)</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16 SOCIAL SECURITY NO <b>566-74-3525</b>	
17 INFORMANT <b>Records U. S. Army</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> DUE TO (b) <b>Skull Fracture</b> DUE TO (c) <b>Trauma-auto accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>22 days</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Driver of car involved in collision</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>11:50 Pm</b> <b>10-14-19 67</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Baltimore Washington Parkway</b>		20f (City or town) (County) (State) <b>Laurel, P.G.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>John Kehoe, M.D., Riverdale, Md.</b>		22. DATE SIGNED <b>11-6-67</b>	
23a BURIAL, CREMATION, or other disposal <b>Burial</b>		23b DATE THEREOF <b>Nov. 1967</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Belvue</b>		23d LOCATION (City or town) (County) (State) <b>Ontario, California</b>	
24. FUNERAL DIRECTOR <b>HOWARD COUNTY FUNERAL HOME of Harry Witzke</b>		25a REGD. BY REGISTRAR <b>Edlicott City Maryland</b>	
25b REGISTRAR'S SIGNATURE <b>NOV 8 1967</b>		25c REGISTRAR'S SIGNATURE <b>George</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15857

15848

1 PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>5015 Hays St., N.E.</b>			
3 NAME OF DECEASED (Type or print) <b>Mannie Hill</b>				4 DATE OF DEATH <b>11 20 19 67</b>			
5 SEX <b>F</b>	6 COLOR OR RACE <b>N</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7 May 1912</b>	9 AGE (In years last birthday) <b>55</b> yrs	10 UNDER 1 YEAR Months Days Hours Min.		11 UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11 BIRTHPLACE (State or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>John T. Jordan</b>				14 MOTHER'S MAIDEN NAME <b>Nannie?</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16 SOC. A. SECURITY NO. <b>—</b>		17 INFORMANT <b>Bessie Stewart - niece</b> Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis fr.</b> <b>0120</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bilateral ileo psoas abscesses</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John Kehoe, M.D., Riverdale, Md.				22. DATE SIGNED <b>11-21-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>11-25-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>		23d. LOCATION (City or Town) (County) (State) <b>Highland Park Rd</b>	
24. FUNERAL DIRECTOR <b>H.S. Washington &amp; Sons 4925 Penna Ave</b> ADDRESS				25a. REC'D BY REGISTRAR <b>NOV 27 1967</b> DATE		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	

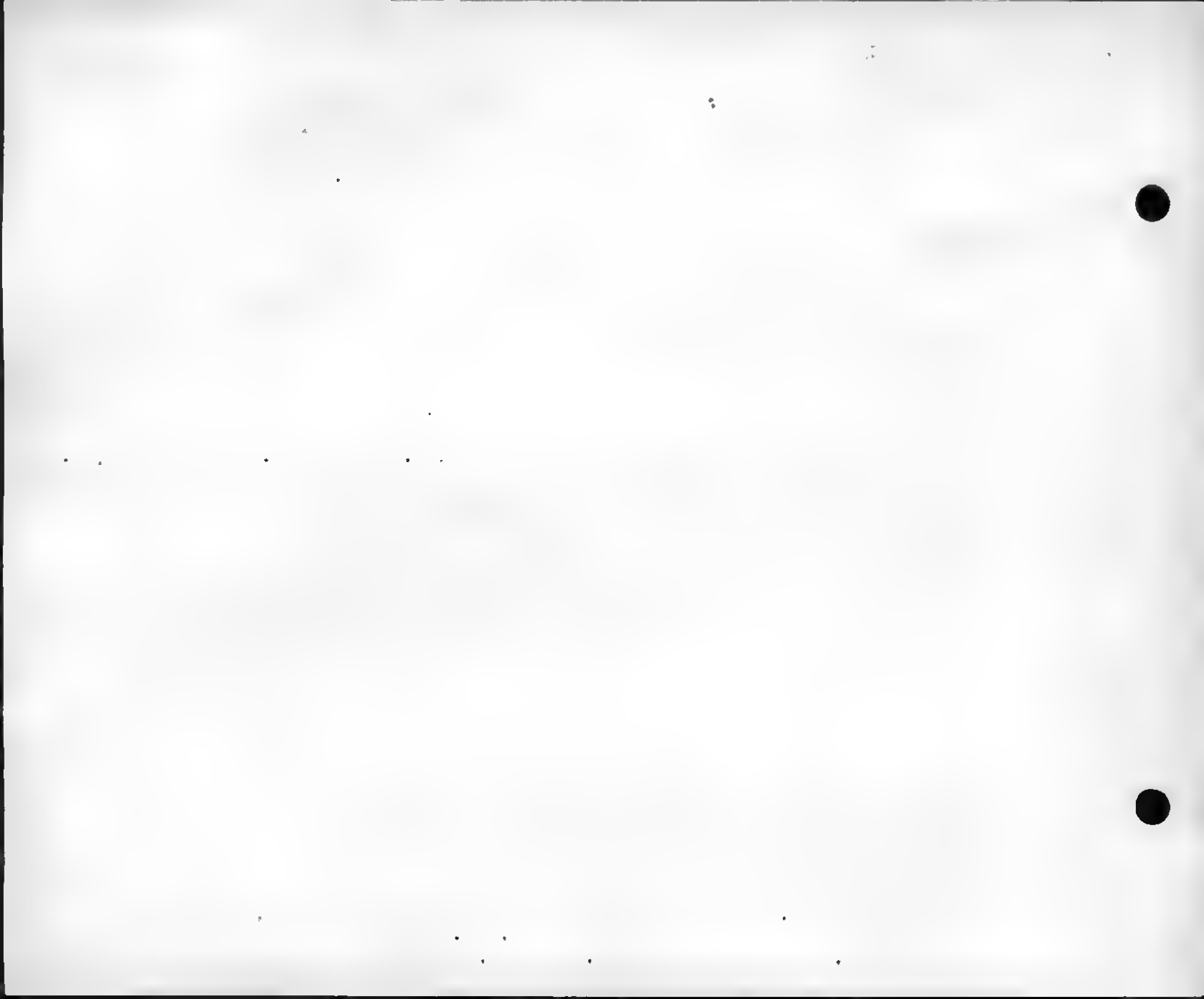


15849

VR A15 (4)  
25M 1/67

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Dowell, Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY in 1b 56 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Calvert Co.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine View Gardens Health Care Center				d. STREET ADDRESS 4701 Stuart Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Henry Hinchliffe				4. DATE OF DEATH November 27 1967			
5. SEX M		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-30-86	
9. AGE (in years last birthday) 81		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Hinchliffe				14. MOTHER'S MAIDEN NAME Ann Ward			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Virgil J. Hinchliffe. Son, Dowell, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Coronary Pulmanal DUE TO (c) Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-2, 1967, to 11-27, 1967, that (I) (we) lost saw the deceased alive on 11-27, 1967, and that death occurred at 11:30 AM, from causes and on the date stated above							
22a. SIGNATURE Alfred R. Lapin M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, M.D.				22d. ADDRESS CLINTON, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 29, 1967		23c. NAME OF CEMETERY OR CREMATORY Christ Episcopal Church Cemetery, Clinton, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Simmons Bros. Funeral Home-1661-Gd. Hope RD. SE		ADDRESS Wash., DC.		25a. REC'D BY REGISTRAR NOV 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15850

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY in 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>M.</b> Last <b>Hinton</b>		4. DATE OF DEATH Month <b>11</b> Day <b>20</b> Year <b>19 67</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 Sept 1934</b>
9. AGE (in years last birthday) <b>33 yrs</b>		10. F UNDER 1 YEAR Months <b>33</b> Days <b>33</b> Hours <b>33</b> Min <b>33</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress-Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>	
13. FATHER'S NAME <b>William Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Mary Brooks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mary Henry-mother</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Trauma</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fell at home striking head</b>	
20c. TIME OF INJURY Month, Day Year <b>7:00 am 11 10 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Same as #2</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>11-21-67</b>	
ACTUAL SIGNATURE <b>John Kehoe</b> EXAMINER'S NAME (Type) <b>John Kehoe, M.D., Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/25/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Maryland</b>	
24. FUNERAL DIRECTOR <b>Stewart Funeral Home-4001 Benning Rd., N.E.</b>		25a. REC'D BY REGISTRAR <b>NOV 22 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





15850

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

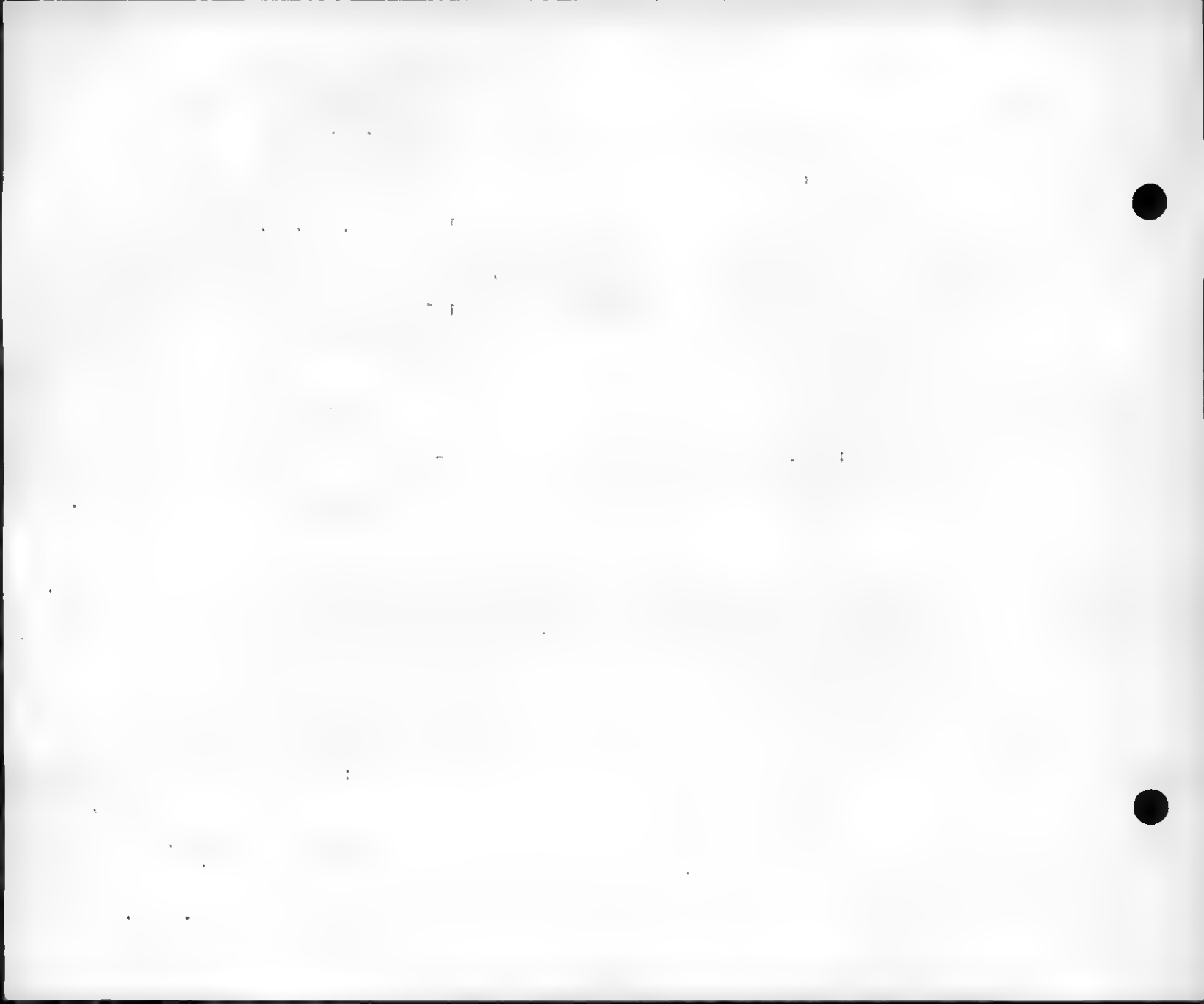
CERTIFICATE OF DEATH

15851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>C</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>			c. LENGTH OF STAY IN 1b <b>19 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>1416 R St., N. W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elmer</b> Middle <b>L.</b> Last <b>Hollowell</b>				4. DATE OF DEATH Month <b>11</b> Day <b>18</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>4/1/1929</b>		9. AGE (In years last birthday) yrs <b>38</b>	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truckdriver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clate Hollowell</b>				14. MOTHER'S MAIDEN NAME <b>Laura Ridley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes 1947-1949</b>		16. SOCIAL SECURITY NO. <b>377-24-4893</b>		17. INFORMANT <b>Decedent</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of the liver, decompensated</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c) <b>chronic alcoholism</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>  <b>20 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>alcoholic cardiomyopathy with congestive failure</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>X</del> (this hospital) attended the deceased from <b>10/30/67</b> to <b>11/18/19 67</b> that <del>X</del> (we) last saw the deceased alive on <b>11/18/19 67</b> , and that death occurred at <b>12:40A</b> M, from causes on and on the date stated above.							
22a. SIGNATURE <i>Moe Weiss</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>				22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 24, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Landover Pr. Geo. Md</b>	
24. FUNERAL DIRECTOR <i>B. F. Taylor</i>				25a. REC'D BY REGISTRAR <i>909624 ST. M.D.</i>		25b. REGISTRAR'S SIGNATURE <i>Glenn Dale</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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1

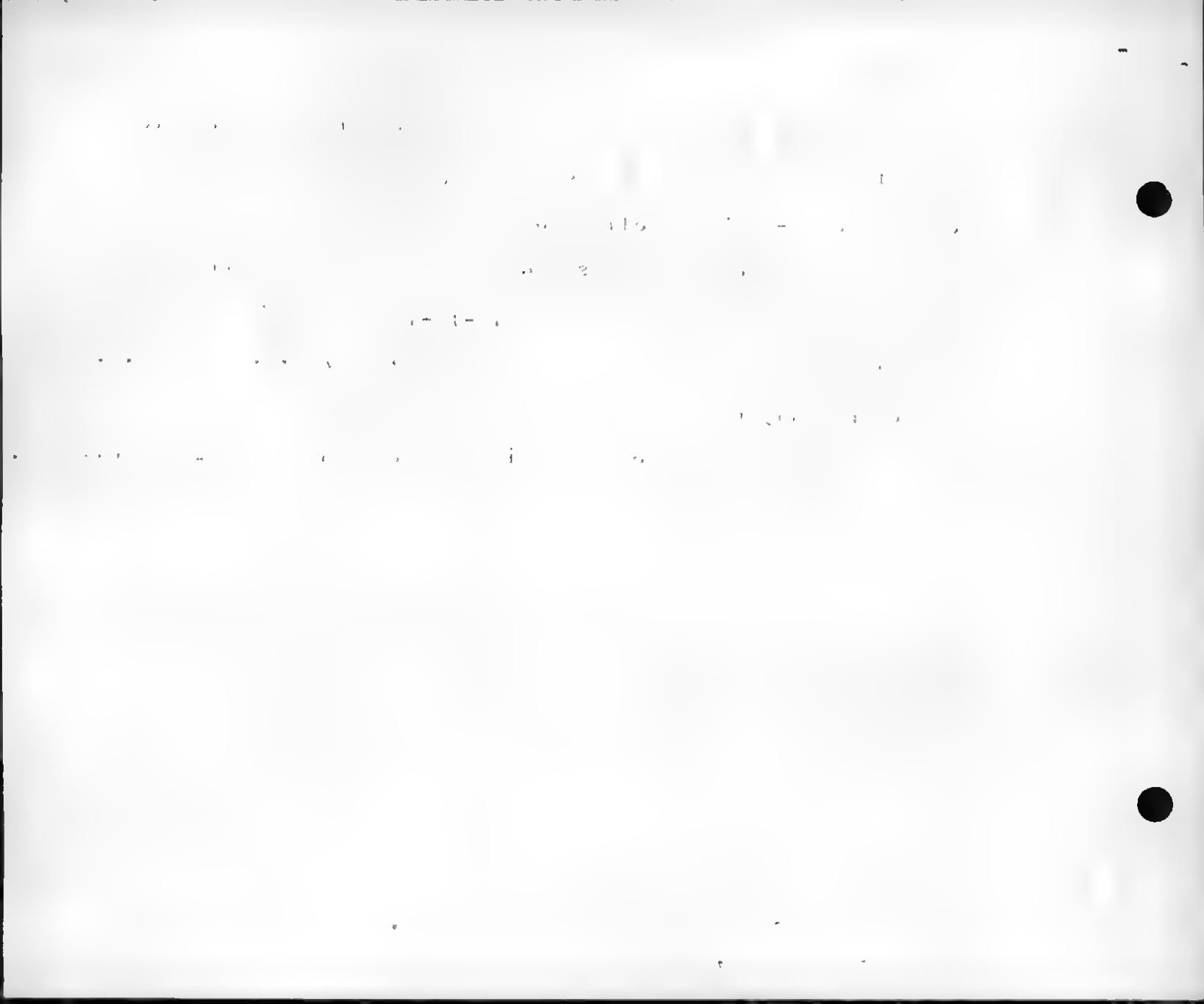
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201.

15861

CERTIFICATE OF DEATH

15852

1 PLACE OF DEATH a COUNTY <b>PRINCE GEORGE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>District of Columbia</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c LENGTH OF STAY IN 1b <b>5 years</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Manor-4922 La Salle Road</b>		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Anna Christina Horan</b>		4 DATE OF DEATH Month Day Year <b>11 13 67</b>	
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12-15-1882</b>
9a AGE (In years last birthday) <b>85</b>		9b IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12 CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13 FATHER'S NAME <b>Benjamin Hellyard</b>		14 MOTHER'S MAIDEN NAME <b>Maye Sauter</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>none</b>	
17 INFORMANT <b>Sister Eliabeth</b>		Address <b>4922 La Salle Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebral Accident right sided</b> DUE TO <b>thromboplegia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>Arteriosclerosis general</b> DUE TO (c) <b>hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Nov 9 1967</b> (Days) <b>Sept 7 1940</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 7 1940</b> to <b>Nov 10 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 10 1967</b> , and that death occurred at <b>7:40 AM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>A. Magister McDonald</b>		22b DATE SIGNED <b>Nov 14 67</b>	
22c PHYSICIAN'S NAME (Type) <b>A. Magister McDonald</b>		22d ADDRESS <b>1746 K ST NW Wash DC</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>11-14-67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cem.</b>		23d LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24 FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a REC'D BY REGISTRAR DATE <b>NOV 17 1967</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles Justice</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

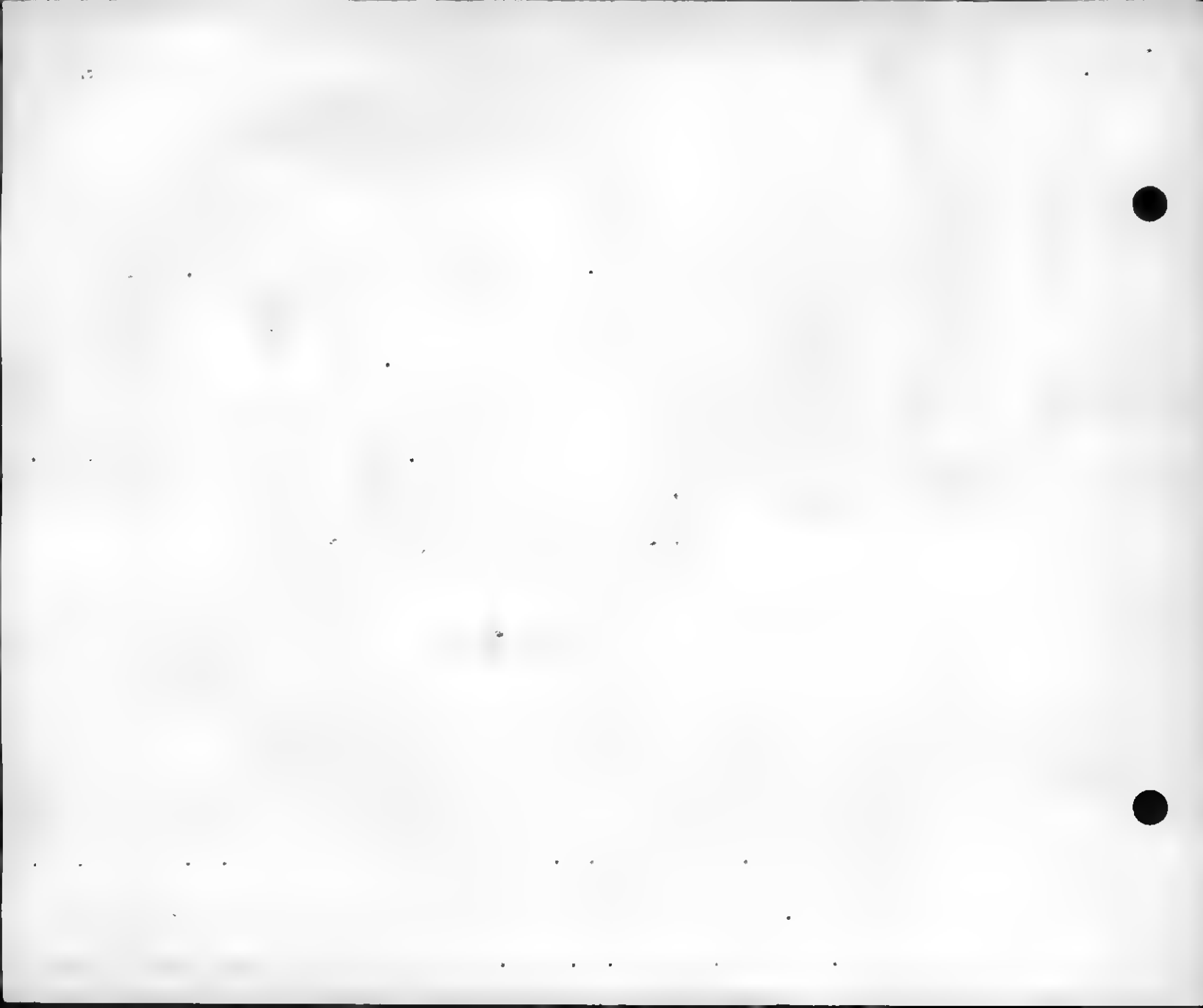
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #23c Film #G391 11/14/67 ph

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) g. STATE <b>District of Columbia</b> b. COUNTY <b>n/a</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>1829 Q Street, SE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harriet E. Howard</b>		4. DATE OF DEATH Month Day Year <b>Nov. 6, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 20 1884</b>
9. AGE (In years lost birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Stratton</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Hartley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Earnest C. Howard (Husband)</b>		Address <b>Same as # 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis &amp; heart disease</b> DUE TO (c) <b>adiposclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>dehydrated &amp; malnourished</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <b>this hospital</b> attended the deceased from <b>Oct 1967</b> to <b>Nov 6, 1967</b> , that (I) <b>saw</b> last saw the deceased alive on <b>11/6</b> 19 <b>67</b> , and that death occurred at <b>10</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Leon R. Levitsky, M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Leon R. Levitsky, M.D.</b>		22d. ADDRESS <b>3408 Rhode Island Ave. Mt. Rainier, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<b>Burial</b>	<b>Nov. 8th, 1967</b>	<b>Washington National Cemetery</b>	<b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>		25a. REC'D BY REGISTRAR	
<b>1661- Gd. Hope Rd. SE. Wash., DC</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Jones</b>	
DATE <b>NOV 8 1967</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

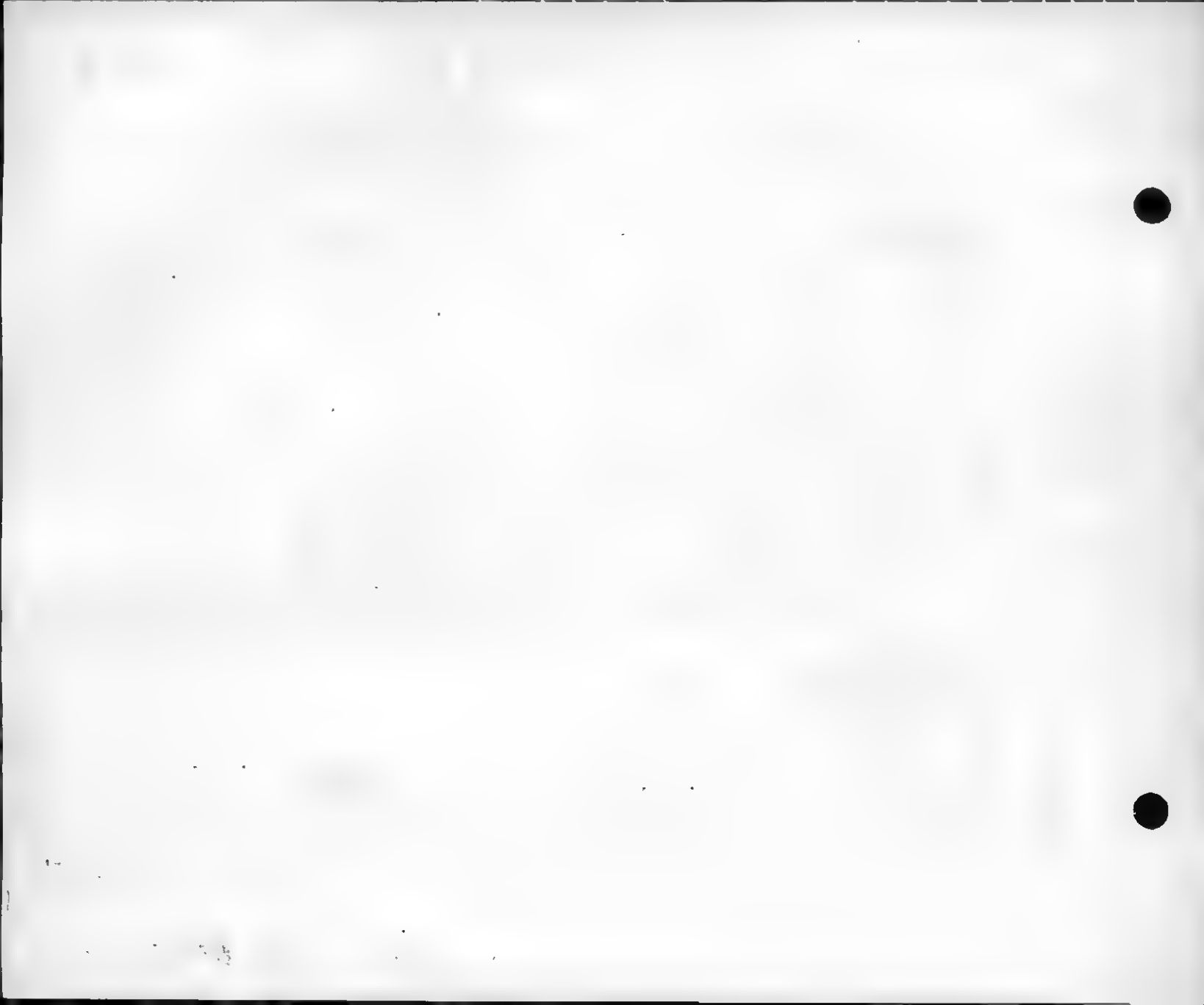
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15854

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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Graveside of the deceased in the cemetery of the deceased.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>-DOA-</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>3900 Hamilton St.</b> e. IS RES. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELSIE M. HOYLE</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>25</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 22, 1873</b>
9. AGE (In years lost birthday) yrs <b>94</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Mann</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Wilmer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>--</b>		16. SOCIAL SECURITY NO. <b>220-54-0361-J1</b>	
17. INFORMANT <b>Anne M Hoyle</b>		Address <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary arteriosclerosis</b> (c) <b>Coronary arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <b>Nov. 25, 1967</b> to <b>Nov. 25, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 25, 1967</b> , and that death occurred at <b>3503 Mt. Rainier St. Md.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Don B. Cameron</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/>	22b. DATE SIGNED <b>11-25-67</b>
22c. PHYSICIAN'S NAME (Type) <b>DON B. CAMERON</b>		22d. ADDRESS <b>3503 MT. RAINIER ST. MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 28, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Chestertown Kent co Md</b>
24. FUNERAL DIRECTOR <b>F Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR <b>DEC 1 1967</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





**FOR STATE  
HEALTH DEPT**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Film 396 1-9-67 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. LENGTH OF STAY IN 1b 44 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing Home				e. STREET ADDRESS 2329 Fairlawn Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last Martha Huffman				4. DATE OF DEATH Month 11 Day 3 Year 19 67			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-97	9. AGE (in years last birthday) 70	10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? GERMANY	
13. FATHER'S NAME GUSTAV JEBE				14. MOTHER'S MAIDEN NAME LAURA TESCHEMACHER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		6. SOCIAL SECURITY NO		17. INFORMANT MRS LORA MIKA		Address 7209 16th Ave TAKOMA PARK MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Undetermined 7/25 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city, town, or county)			
23a. BURIAL (CREMATION) REMOVAL (Specify)		23b. DATE THEREOF 11/7/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or town) (County) (State) Pn Geo Co. Md.	
24. FUNERAL DIRECTOR Address				25a. REC'D BY REGISTRAR NOV 9 1967		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

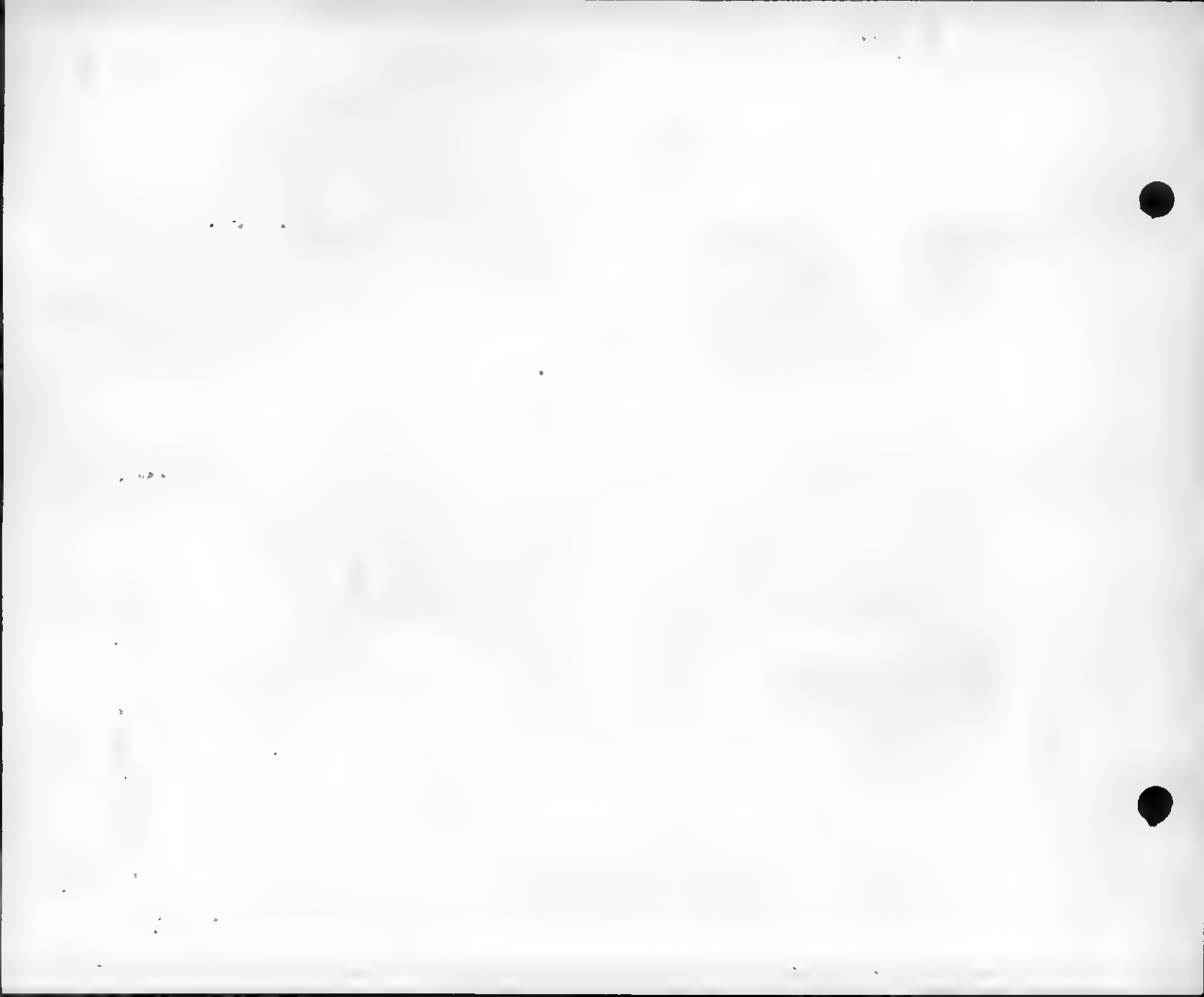
15865

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

15856

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>WASH. DC.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASH. DC.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL MANOR 4922 LASALLE RD.</u>				d. STREET ADDRESS <u>821 Emerson St. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOSEPHINE HUNNICHT</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 3, 1879</u>		9. AGE (In years last birthday) <u>87</u> yrs.	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life) <u>Retired sales lady-Saks Fur Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>		12. CIT. ZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JOSEPH HESSE</u>				14. MOTHER'S MAIDEN NAME <u>JOSEPHINE HAAS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>578-01-4637</u>		17. INFORMANT <u>Dr. Leonard J. Foster</u> Address <u>Hyattsville, Md. 4922 La Salle Rd.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TANITION AND MALNUTRITION</u> DUE TO (b) <u>Abdominal Malignancy Undet. Type</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>Nov</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>NOV 10</u> , 19 <u>67</u> , and that death occurred at <u>2:10 P.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>James J. Foster</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES J. FOSTER</u>				22d. ADDRESS <u>1744 K St. N.W.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>S.H. Hines Co. Wash. D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

15866

15857

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Pro Geo</b>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c LENGTH OF STAY IN 1b <b>28 days</b>		
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d STREET ADDRESS <b>3704 Jefferson st</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>Bertha C Issing</b>			4 DATE OF DEATH Month <b>Nov</b> Day <b>24</b> Year <b>1967</b>		
5. SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Dec 11, 1896</b>		9 AGE (In years last birthday) <b>70 yrs</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Brooklyn N Y</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>John Burkhardt</b>			14. MOTHER'S MAIDEN NAME <b>Rose Weik</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>092 07 5976A</b>	17. INFORMANT Address <b>Hospital records Cheverly, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinoma of brain</u> DUE TO (b) <u>Carcinoma of Breast</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)			
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-13</u> , 19 <u>67</u> , to <u>11-23</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11-23</u> , 19 <u>67</u> , and that death occurred at <u>5:20A</u> M. from causes and on the date stated above.					
22a SIGNATURE 		22b DATE SIGNED <b>11-23-67</b>		22c PHYSICIAN'S NAME (Type) <b>Aaron Deitz, M. D.</b>	
22d ADDRESS <b>Prince Georges Plaza, Hyattsville, Md.</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>Nov 27, 1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>F. Gasch's Sons Hyattsville, Md.</b>			25a REC'D BY REGISTRAR DATE <b>NOV 27 1967</b>	25b REGISTRAR'S SIGNATURE 	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5867

15858

1 PLACE OF DEATH a COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a STATE <b>Maryland</b> b COUNTY <b>Prince George's</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c LENGTH OF STAY IN 1b <b>6 hours</b>	
d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		d STREET ADDRESS <b>4275 58th avenue</b>	
3 NAME OF DECEASED (Type or print) <b>Frances Jane Johnson</b>		4 DATE OF DEATH Month <b>Nov</b> Day <b>12</b> , Year <b>1967</b>	
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Nov 25, 1918</b>
9 AGE (In years last birthday) <b>48</b> yrs		10 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11 BIRTHPLACE (State or foreign country) <b>Pro Geo co Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U S A.</b>	
13 FATHER'S NAME <b>William B Markward</b>		14 MOTHER'S MAIDEN NAME <b>Ruth V Dempsey</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Edward F. Johnson</b>		Address <b>Bladensburg, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>7955</b> IMMEDIATE CAUSE (a) <b>Subdural Hematoma</b> DUE TO <b>Trauma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTR BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>Unknown</b>	
20c. TIME OF INJURY Month, Day, Year Hour: a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		ASS- STANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 16, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Wood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Vienna Va</b>	
24 FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 1 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

③ 3-Methyl-4-vinyl-2-pentene-4



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

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VR A15ME  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15863

15859

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN Tb <b>nine hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b> 16	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>Box 229-C Floral Park Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marie Elizabeth Johnson</b>			4. DATE OF DEATH Month Day Year <b>11 4 19 67</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-14-1914</b>	9. AGE (In years last birthday) <b>23</b> yrs	IF UNDER 1 YEAR Months Days Hours Min <b>11 4 19 67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>P. Geo's. Co. Md.</b>	
13. FATHER'S NAME <b>Richard Duckett</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Hawkins</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <b>Preston Johnson</b> Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b> DUE TO (b) _____ DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____					INTERVAL BETWEEN ONSET AND DEATH <b>9 hours</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>shot by assailant</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>11-4 19 67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>driveway of Box 369, Brandywine, P.G., Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>11-6-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>Brandywine P.G. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-11-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Ch. Cem.</b>	
24. FUNERAL DIRECTOR <b>Marcell Adams</b>		ADDRESS <b>Aquasco, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

DAT NOV 14 1967



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

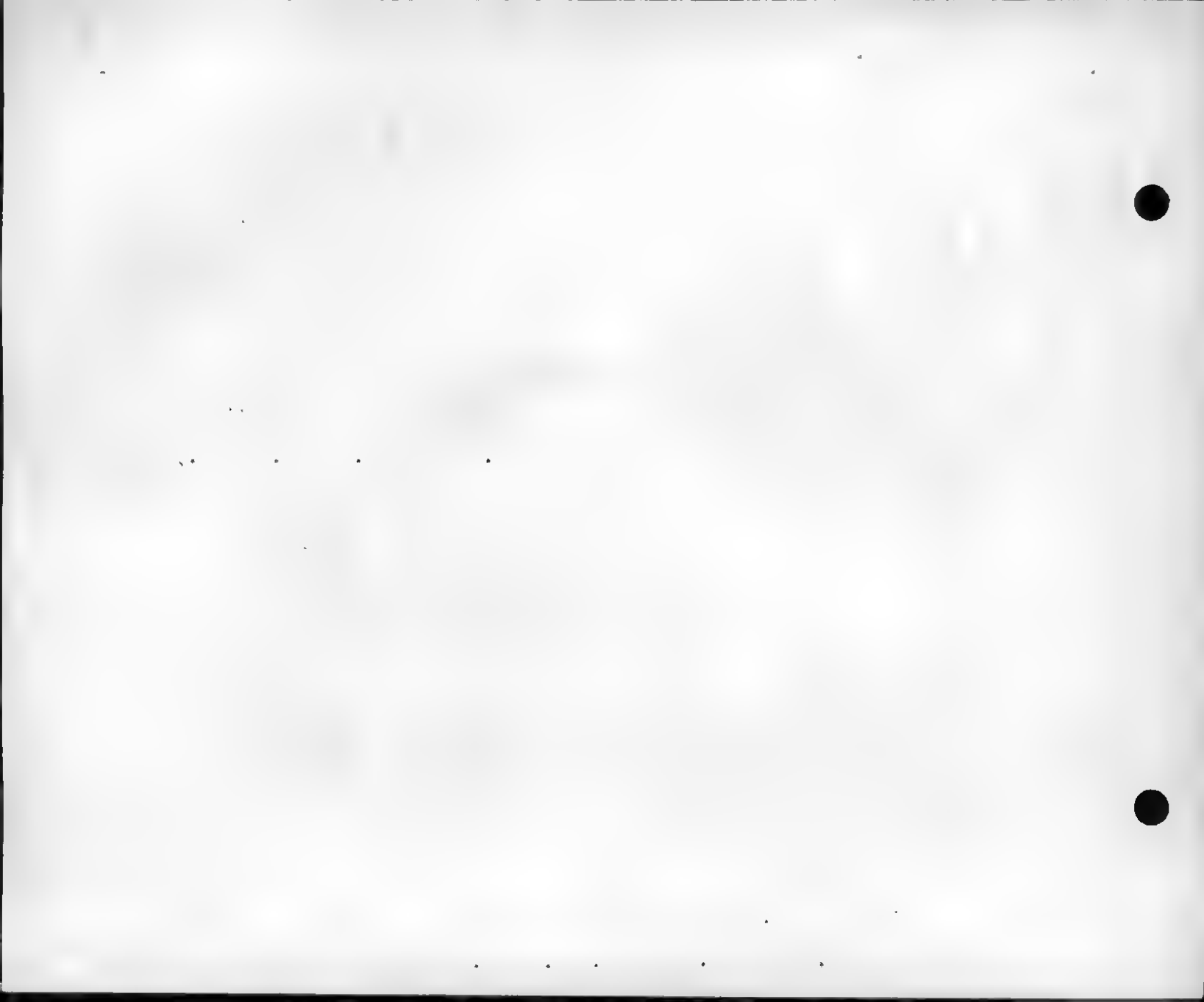
15868

15860

1. PLACE OF DEATH a. COUNTY <u>P.G.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Pd.</u> b. COUNTY <u>SE P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill Md.</u>	
c. LENGTH OF STAY in 1b <u>7-14-67</u>		d. STREET ADDRESS <u>1002 - palmer Road S.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Claude</u> Middle <u>H.</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-17-'08</u>
9. AGE (In years last birthday) <u>59</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police Officer Retired U.S. Gov.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James Jones</u>		14. MOTHER'S MAIDEN NAME <u>Emma Nichols</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Lucille D. Smith. (Dau.)</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adeno Carcinoma</u> DUE TO (b) <u>metastatic Prostatic Carcinoma</u> DUE TO (c) <u>metastatic Prostatic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u> <u>5 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-14</u> , 19 <u>67</u> , to <u>11-12</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>11-11</u> , 19 <u>67</u> , and that death occurred at <u>1:15</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>W.B. Sheer</u>		22b. DATE SIGNED <u>11-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER B. SHEER</u>		22d. ADDRESS <u>6040 MARLBORO PIKE S.E. WASH. DC.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 13 1967</u>	
ADDRESS <u>Simmons Bros. 1661- Gd. Hope Rd. SE. Wash., DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

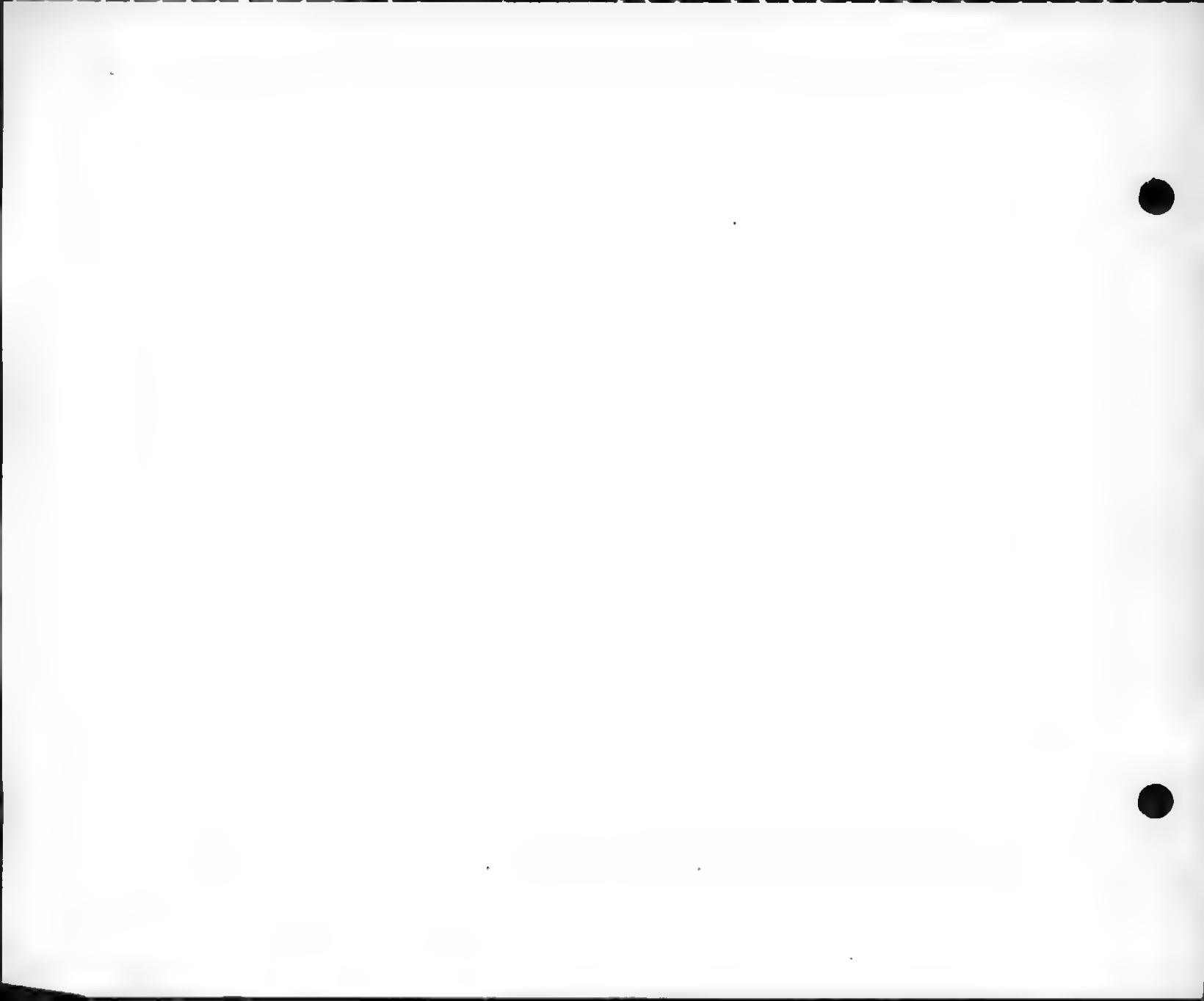
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15870

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

15861

1 PLACE OF DEATH a COUNTY <b>Prince George's</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Prince George's</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c LENGTH OF STAY IN 1b <b>2 hrs</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d STREET ADDRESS <b>6801 Riggs Road</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Mary Alice Jones</b>				4 DATE OF DEATH Month Day Year <b>11 12 19 67</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12-7-1900</b>	9 AGE (in years last birthday) <b>66</b> yrs	f UNDER 1 YEAR Months Days		g UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11 BIRTHPLACE (State or foreign country) <b>Gen.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Samuel Lamons</b>				14 MOTHER'S M.A.DEN. NAME <b>Bertha Bryant</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16 SOCIAL SECURITY NO. <b>1</b>		17 INFORMANT Address <b>Ernest David Jones, Prince Frederick, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> 7 x x x DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) lost } DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		RIVERDALE, Md.		22. DATE SIGNED <b>11-13-67</b>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <b>Nov. 15, 1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>Ashbury Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Bethesda, Calverton Co. Md.</b>	
24 FUNERAL DIRECTOR <b>A. G. Shirkness &amp; Sons, Inc., Baltimore, Md.</b>				25 REC'D BY REGISTRAR DATE <b>NOV 16 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

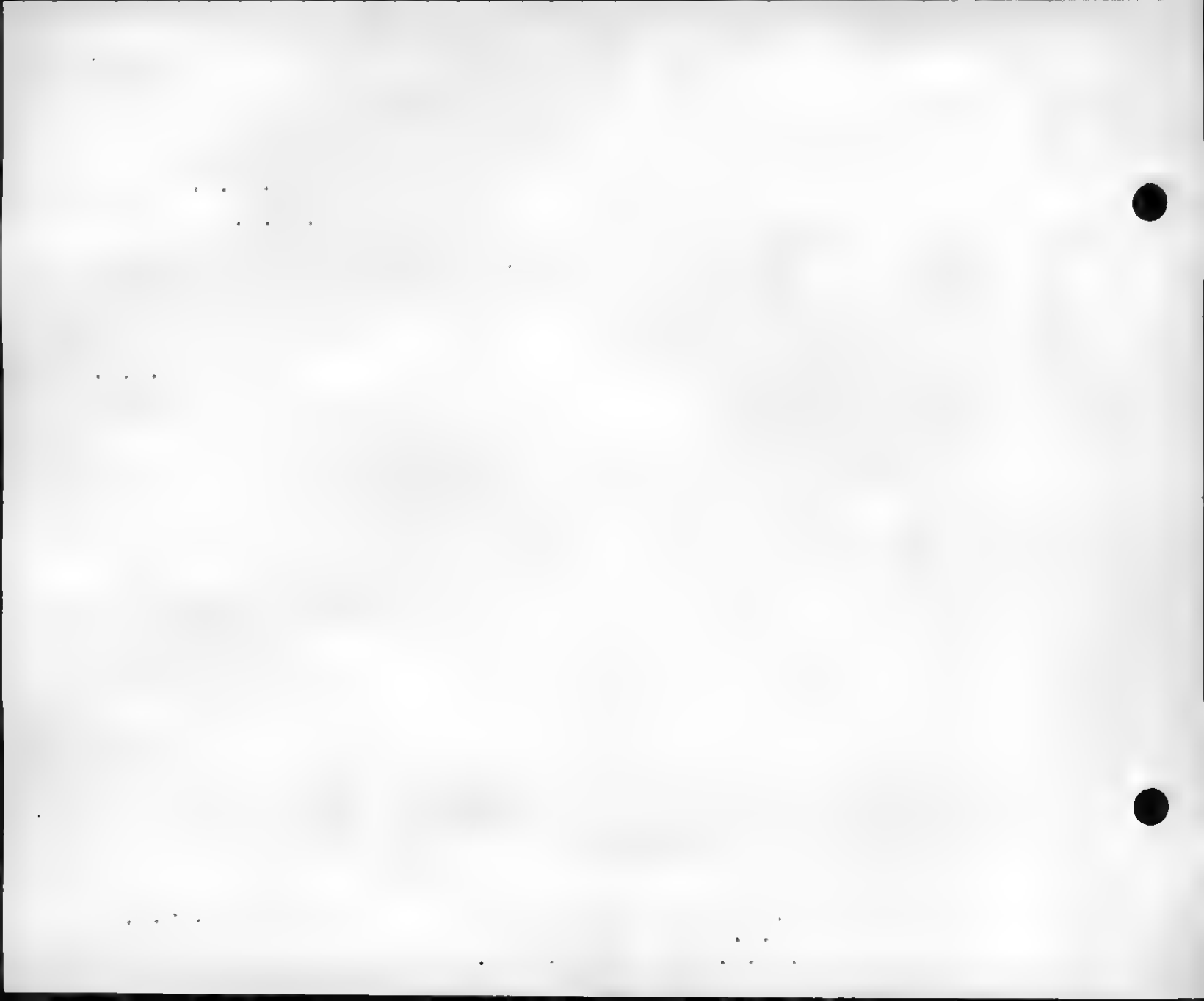


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

<div style="display: flex; justify-content: space-between;"> <span>15871</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>15862</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1 PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7420 Marlboro Pike The Regent Nursing Home</b>						<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>112 65th St. S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3 NAME OF DECEASED</b> (Type or print) First <b>Anastasios</b> Middle <b>Karavangelos</b> Last <b>Karavangelos</b>						<b>4 DATE OF DEATH</b> Month <b>Nov.</b> Day <b>6</b> Year <b>1967</b>					
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8/16/92</b>		<b>9. AGE</b> (In years last birthday) <b>75</b> yrs		<b>IF UNDER 1 YEAR</b> Months Days Hours Min	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Restaurant owner</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Greece</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Greece</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Marcos Karavangelos</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Anna Karavangelos same as #2</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO <b>Coronary artery disease</b> (b) <b>Advanced A.S.C.V.D.</b> DUE TO <b>Advanced A.S.C.V.D.</b> (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>4 yrs</b>	
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. 19 p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>July, 1961</u> to <u>Nov. 6, 1967</u>, that (I) (we) last saw the deceased alive on <u>Nov. 4, 1967</u>, and that death occurred at <u>7:00 PM</u>, from causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <b>F. Joseph Weber</b>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>Nov. 6, 67</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>F. JOS. WEBER</b>						<b>22d. ADDRESS</b> <b>3230 PENNA AVE, SE.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>burial</b>		<b>23b. DATE THEREOF</b> <b>11/9/67</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Glenwood Cemetery</b>		<b>23d. LOCATION</b> (City or Town) (County) (State) <b>Washington, D.C.</b>					
<b>24. FUNERAL DIRECTOR</b> <b>The S.H. Hines Company</b> <b>2901 14th St. N.W. Washington, D.C.</b>						<b>25a. REC'D BY REGISTRAR</b> <b>DATE NOV 9 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

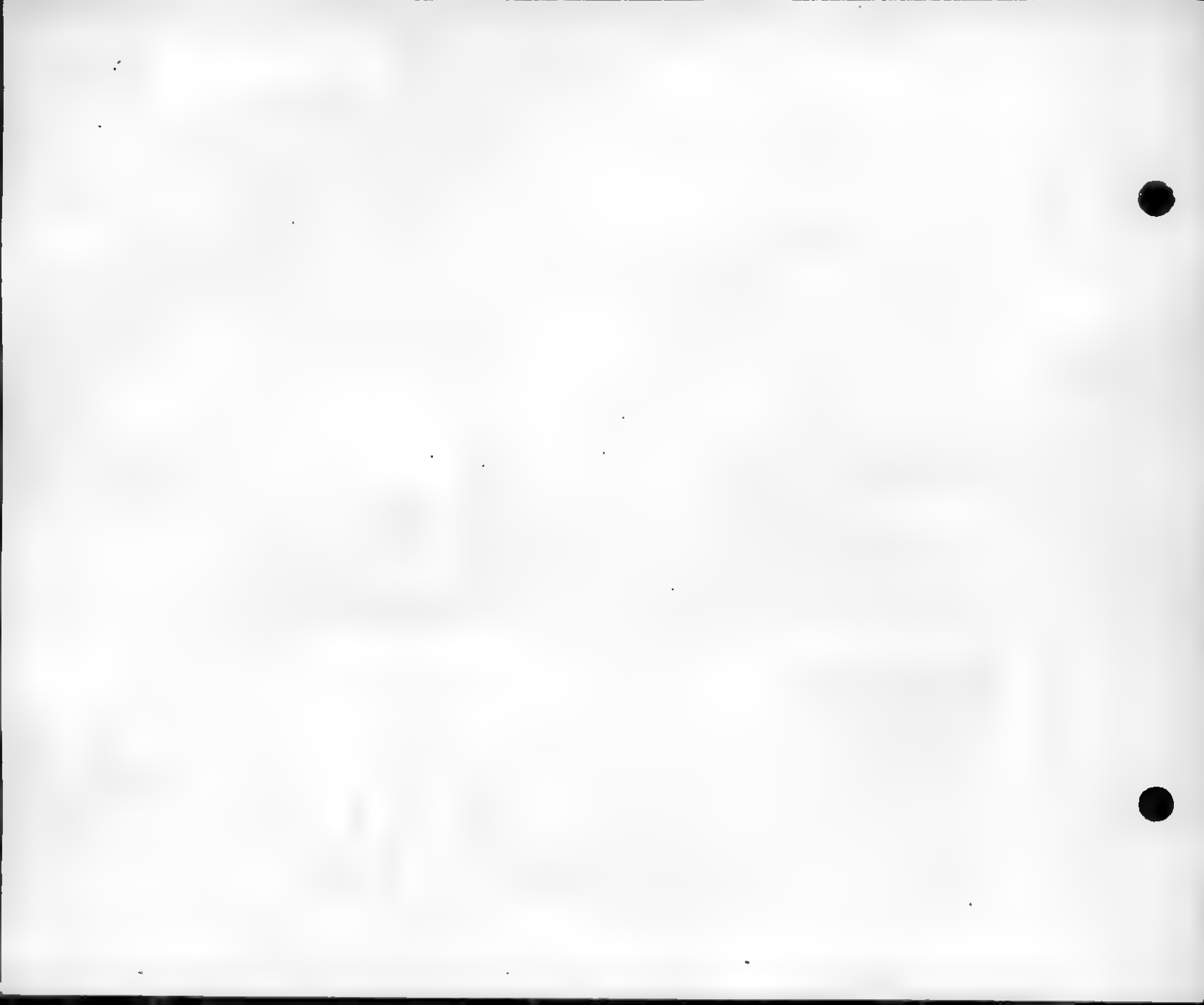
15878

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

15863

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>323 Main Street</u>		d. STREET ADDRESS <u>323 Main Street</u>	
3. NAME OF DECEASED (Type or print) <u>FLORENCE MYRTLE KELLER</u>		4. DATE OF DEATH <u>Nov 6 19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 5 1912</u>
9. AGE (In years last birthday) <u>55 yrs</u>		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Co-owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>news agency</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Beall</u>		14. MOTHER'S MAIDEN NAME <u>Eva Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>C. R. Keller</u>		Address <u>323 Main Street Laurel Md.</u>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Coronary Atherosclerosis</u> DUE TO <u>57yr</u> (c) <u>Hypertensive C-V-R Dis.</u> <u>16yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mild Diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/17</u> , 19 <u>57</u> , to <u>7/16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/16</u> , 19 <u>67</u> , and that death occurred at <u>3P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. M. Warren</u>		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>J. M. Warren</u>		22d. ADDRESS <u>Laurel Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-9-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Laurel Md</u>	
24. FUNERAL DIRECTOR <u>De Witt Davidson</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>Laurel Md</u>		DATE <u>NOV 13 1967</u>	



15873

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

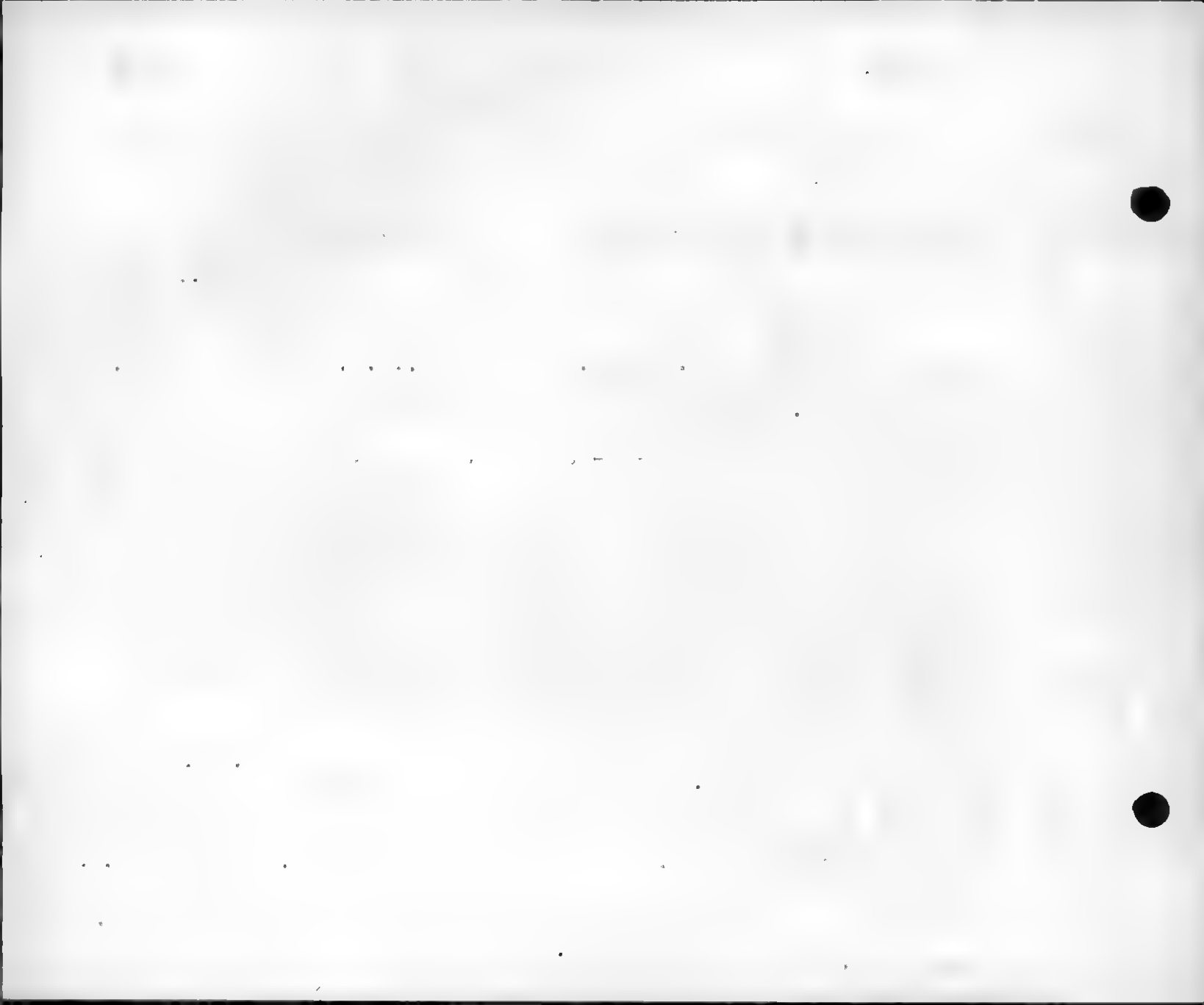
CERTIFICATE OF DEATH

15034

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevelry</b>				c. LENGTH OF STAY IN 1b <b>22 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>8477 Glendale Road</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>B</b> Last <b>Kessler</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>22</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 June 1910</b>	9. AGE (In years lost birthday) <b>57</b> yrs	10. IF UNDER 1 YEAR Months <b>5</b> Days <b>18</b> Hours <b>5</b> Min <b>18</b>		11. IF UNDER 24 HRS Months <b>5</b> Days <b>18</b> Hours <b>5</b> Min <b>18</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Wash., D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James B. Kessler</b>				14. MOTHER'S MAIDEN NAME <b>Kate Dixon</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-22-0545</b>		17. INFORMANT <b>Mrs. Faith M. Kessler (above address)</b> Address <b>(Wife)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Peritonitis</b> <b>516X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchopneumonia, bilateral</b> DUE TO (c) <b>5 Days</b>						INTERVAL BETWEEN ONSET AND DEATH <b>18 Days</b> <b>5 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 19 67</b> , to <b>Nov. 22, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 22, 1967</b> , and that death occurred at <b>5:40 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Samuel Sugar</b>				22b. DATE SIGNED <b>Nov 22 '67</b>		22c. PHYSICIAN'S NAME (Type) <b>Samuel Sugar, M. D.</b>	
22d. ADDRESS <b>4637 Eastern Ave. Washington, D.C. 20018</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/25/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>				25a. REC'D BY REGISTRAR <b>DATE NOV 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

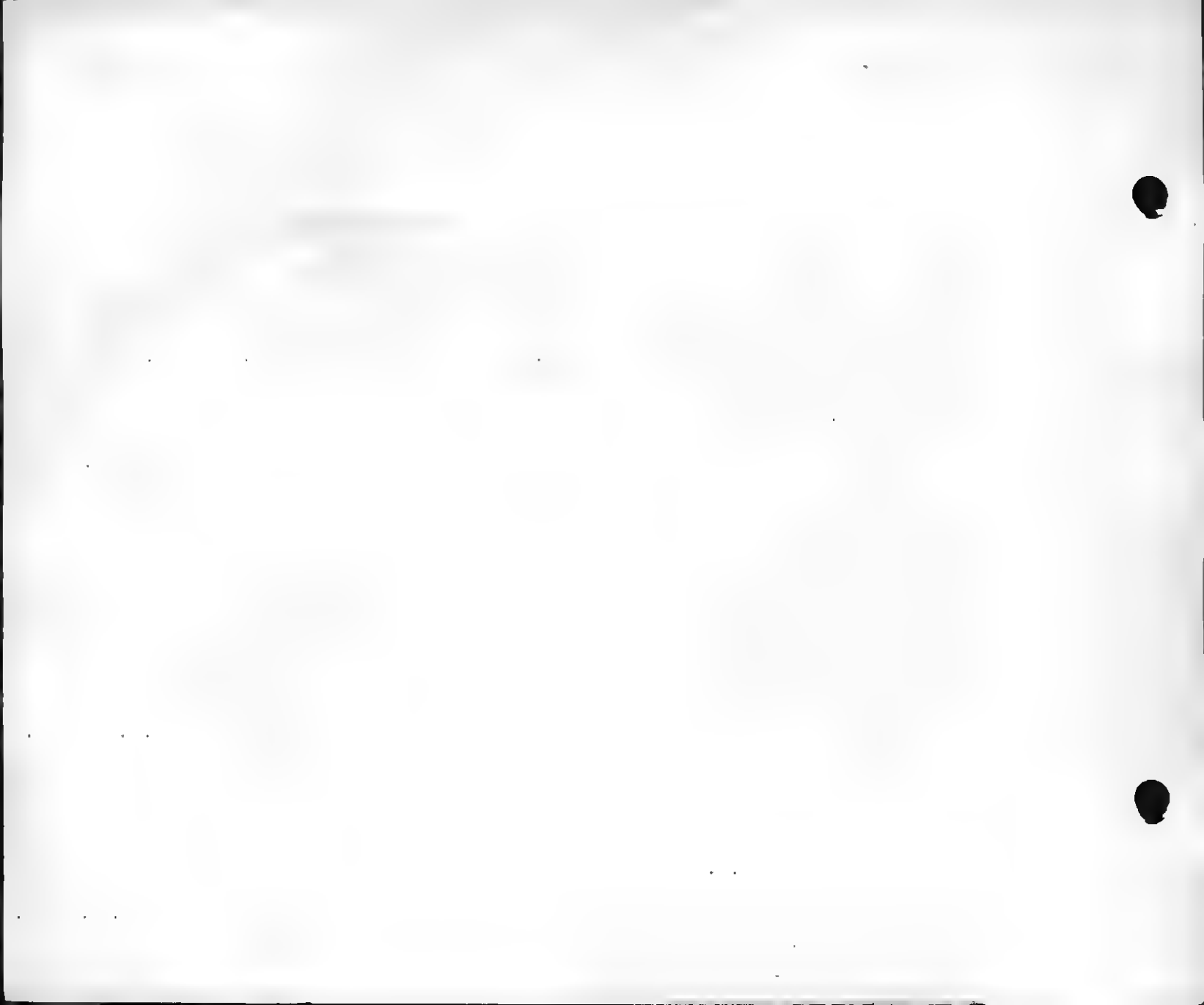
VR A15ME (5)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15685

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>4504 Knox Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <b>Lloyd Alexander Kessler</b>			4 DATE OF DEATH Month Day Year <b>11 17 19 67</b>		
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1-17-07</b>	9 AGE (in years last birthday) <b>60</b> yrs	F UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Groundsman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. of Maryland</b>		11 BIRTHPLACE (State or foreign country) <b>Prince George, Md.</b>	
13. FATHER'S NAME <b>Clarence S. Kessler</b>			14 MOTHER'S MAIDEN NAME <b>Agnes C. Woodward</b>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>561 48 5705</b>		17 INFORMANT <b>Charles R. Kessler</b> Address <b>6737 Riverdale Road Riverdale, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Laceration of brain</b> <b>x 124</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Trauma - auto accident</b> DUE TO (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>pedestrian struck by car</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>8:30 a.m. 11-17 19 67</b>		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work or work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. Route 1</b>		20f. (City or town) (County) (State) <b>College Park P.G. Md.</b>
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Kehoe M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>11-18-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/22/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	
24 FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 22 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Pages 1, 2, and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15875

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15866

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Riverdale		c LENGTH OF STAY IN lb six days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d STREET ADDRESS 1019 3th Street		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Michael Stanton Keys				4 DATE OF DEATH 11 11 19 67			
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 2-11-49	9 AGE (In years last birthday) 18 yrs	IF UNDER 1 YEAR Months Days Hours Min.		
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) student		10b KIND OF BUSINESS OR INDUSTRY high school		11 BIRTHPLACE (State or foreign country) Md		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Keefer George Keys				14 MOTHER'S MAIDEN NAME Gwendoline Harriett Hays			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16 SOC. A. SECURITY NO		17 INFORMANT Keefer Keys Address Rhames			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Trauma - auto accident DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH six days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) passenger in car involved in accident					
20c TIME OF INJURY Month, Day, Year Hour a.m. pm 11-5 1967		20a INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 4900 Powdermill Rd. Beltsville P.G. Md.		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 11-12-67			
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)			
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 11-14-67		23c NAME OF CEMETERY OR CREMATORY Inverhill Cemetery Laurel Md		23d LOCATION (City or Town) (County) (State)	
24 FUNERAL DIRECTOR De Witt Canadian, Laurel, Md.				25a RECD BY REGISTRAR		25b REGISTRAR'S SIGNATURE Charles Judge	
				DATE NOV 16 1967			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15876

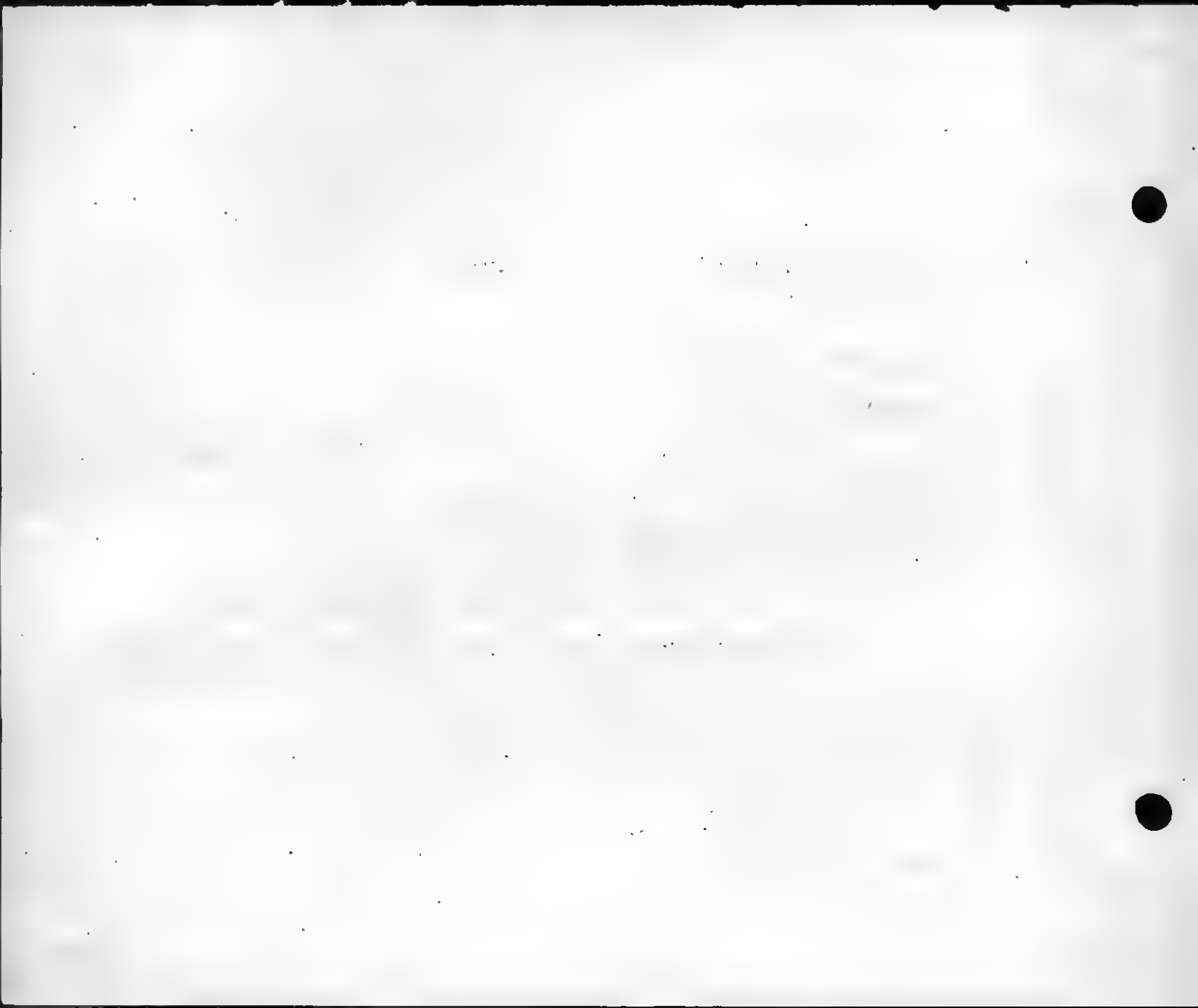
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15877

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Magnolia Gardens Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> d. STREET ADDRESS <u>5600 - 54<sup>th</sup> Ave. apt. 619</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Margaret</u>		First Middle Last <u>Kercher</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 2, 1881</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>19</u> Min. <u>67</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>			
13. FATHER'S NAME <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>070 38 2507</u>		17. INFORMANT <u>WILLIAM KIRCHER JR.</u> Address <u>5600 54<sup>th</sup> Ave Riverdale, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>pneumonia</u> DUE TO (c) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>16 hrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Arteriosclerosis</u>					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10/24/67</u> , 19 <u>67</u> , to <u>11/1/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/1/67</u> , 19 <u>67</u> , and that death occurred at <u>1:20 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Leon Levitsky</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-1-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>LEON LEVITSKY</u>			22d. ADDRESS <u>3408 P.I. AVE MT. RAINIER, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6 Nov. 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MAPLE GROVE MEMORIAL PK.</u>	23d. LOCATION (City, town or county) (State) <u>KEW GARDENS L.I. N.Y.</u>				
24. FUNERAL DIRECTOR <u>WW CHAMBERS CO</u>			ADDRESS <u>RIVERDALE, MD.</u>				
25a. REC'D BY REGISTRAR <u>NOV 3 1967</u>			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15877

15868

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE 710 Mass. Ave. N.E. Wash. D.C. ✓ b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY in 1b one year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		d. STREET ADDRESS 910 Mass. Ave. N.E.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hyattsville Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Olive Knipe				4. DATE OF DEATH Month Day Year November 7 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-1885		9. AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian - Library of Congress (Retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Norristown, Penn		12. C. TIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Oliver Knipe				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO		17. INFORMANT Address Marjorie F. McNall-912 Elm Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 110X Carcinomatosis (General) DUE TO Carcinoma Breast (Primary) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) 4 years				TAKOMA PARK, MD. INTERVAL BETWEEN ONSET AND DEATH 3 years			
2. MEDICAL CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease (16 years)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1966 to 11-7-67, that (I) (we) last saw the deceased alive on 11-6-67 and that death occurred at 10 AM, from causes and on the date stated above							
22a. SIGNATURE P. J. McNulty M.D.		22b. DATE SIGNED 11-7-67		22c. PHYSICIAN'S NAME (Type) P. J. McNulty		22d. ADDRESS 1616 E. CAPITOL ST. WASH. DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 11/9/67		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City or town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR ADDRESS SHHINES Co. 2901 14th NW DC				25a. REC'D BY REGISTRAR DATE NOV 10 1967		25b. REGISTRAR'S SIGNATURE [Signature]	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item #1 Film G-95 14/21/67 KK

15878

15869

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> c. LENGTH OF STAY IN TB <u>5 mos</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4410 Oglethorpe St. Apt. 717</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>4410 Oglethorpe St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>ANTON KOERBER</u>				<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>10</u> Year <u>1967</u>									
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6/13/1892</u>		<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Baltimore, Md.</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>USA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>			
<b>13. FATHER'S NAME</b> <u>Frederick W Koerber</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Weigan</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>577-404925</u>				<b>17. INFORMANT</b> <u>Rose Koerber</u> Address <u>(daughter) as above</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO (b) <u>Carcinoma of Prostate &amp; Bladder</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>8/12</u> <u>1967</u> <b>to</b> <u>11/10</u> <u>1967</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>11/10</u> <u>1967</u> , <b>and that death occurred at</b> <u>2:30</u> <u>M</u> , <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>John W Winkler Jr</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>JOHN W WINKLER JR MD</u>						<b>22d. ADDRESS</b> <u>5800 10th St Hyattsville Md</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>11/14/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parkwood Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>A. K. Huntzmann</u> ADDRESS <u>5732 Georgia Ave. N.E.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>NOV 14 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



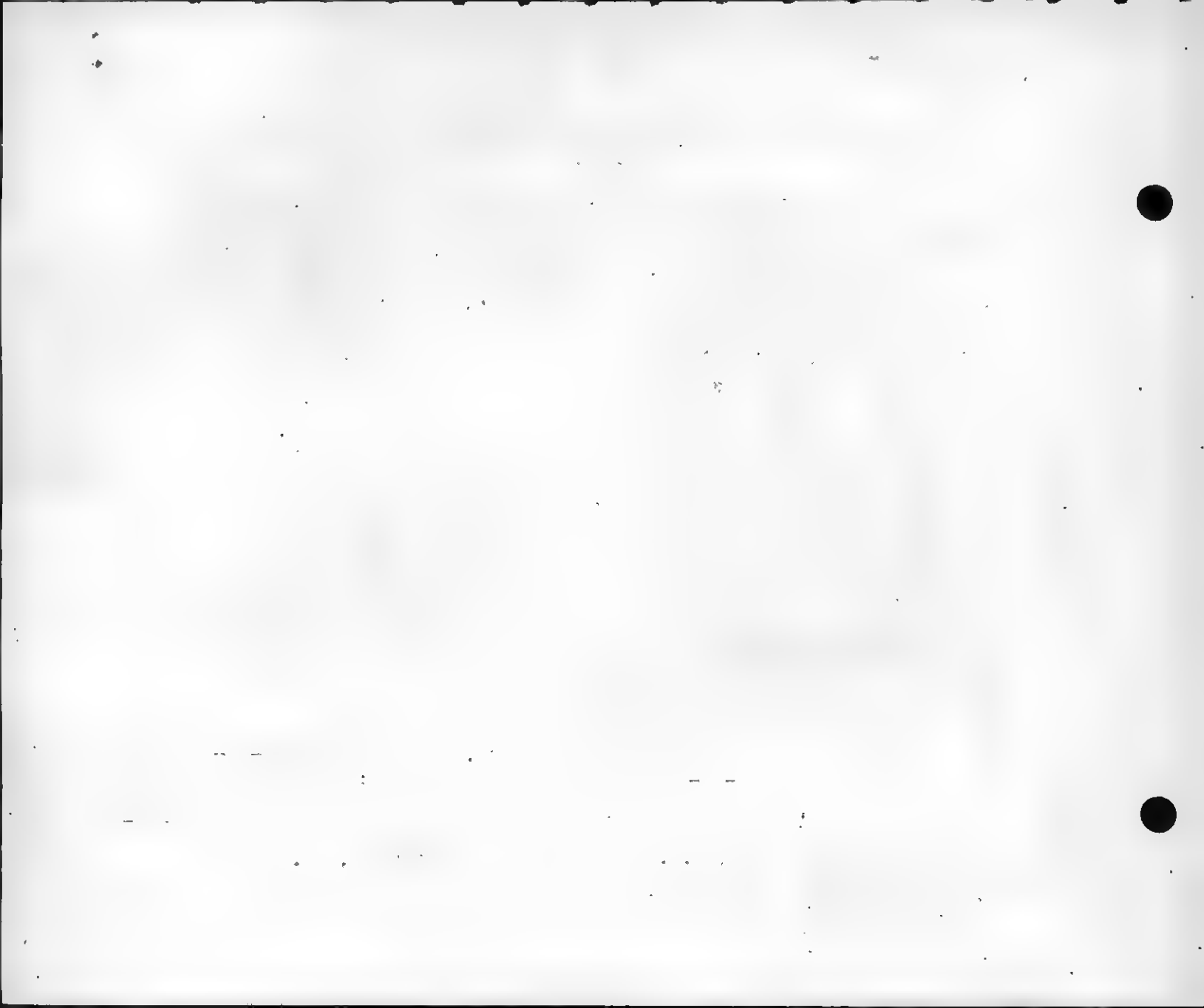
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15879  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b> c. LENGTH OF STAY IN 1b <b>7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PRINCE GEORGES GENERAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SEABROOK</b> d. STREET ADDRESS <b>9329 WELLINGTON ST</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SHIRLEY E. LAVERY</b>		4. DATE OF DEATH Month Day Year <b>Nov 23 1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 7 1923</b>
9. AGE (In years last birthday) <b>44 yrs.</b>		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE, SECY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CT. NATL BANK</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MICHIGAN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>UNKNOWN TYRER</b>		14. MOTHER'S MAIDEN NAME <b>OLGA SALSEN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>384 128320</b>	
17. INFORMANT <b>ROBERT E. LAVERY</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Polycystic kidneys</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug.</b> , 19 <b>61</b> , to <b>11-23-</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-22-67</b> , 19 <b>67</b> , and that death occurred at <b>6:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John Kehoe</b>		22b. DATE SIGNED <b>11-24-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John Kehoe, M.D.</b>		22d. ADDRESS <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11-27-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. ISADORES CEM</b>	23d. LOCATION (City, town or county) (State) <b>MOOLTREE, CO. ILLINOIS</b>
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	
ADDRESS <b>RIVERDALE, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>William W. Chambers</b>	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

15880

15871

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>			c. LENGTH OF STAY IN 1b <b>12 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nottingham</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Southern Md. Medical Center</b>				d. STREET ADDRESS <b>--</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>WILLIAM</b> Middle <b>LAW</b> Last				<b>4. DATE OF DEATH</b> Month <b>11</b> Day <b>17</b> Year <b>1967</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>July 12, 1881</b>		<b>9. AGE</b> (In years last birthday) <b>86</b> yrs	<b>10. IF UNDER 1 YEAR</b> Months <b>11</b> Days <b>17</b>	<b>11. IF UNDER 24 HRS</b> Hours <b>19</b> Min. <b>67</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Employee</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> (Public Utility) <b>Telephone Co.</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Scotland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Unknown</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO</b> <b>----</b>		<b>17. INFORMANT</b> Address <b>20870</b> <b>Mr. Russell Buck-Upper Marlboro, Md.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Circulatory Collapse</u> DUE TO <u>one to Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Arteriosclerosis CHD H AD</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f.</b> (City or town) (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>11-6</u>, 19<u>67</u> to <u>11-17</u>, 19<u>67</u> that (I) (we) last saw the deceased alive on <u>11-16</u> 19<u>67</u>, and that death occurred at <u>10:30</u> A.M. from causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Alfred R. Lapin</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>11/17/67</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>ALFRED R. LAPIN</b>				<b>22d. ADDRESS</b> <b>Clinton, Maryland.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11/20/67</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Thomas Cemetery</b>		<b>23d. LOCATION (City or Town) (County) (State)</b> <b>Croom Md.</b>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Ritchie Bros. Upper Marlboro, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>NOV 22 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b>	



100

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

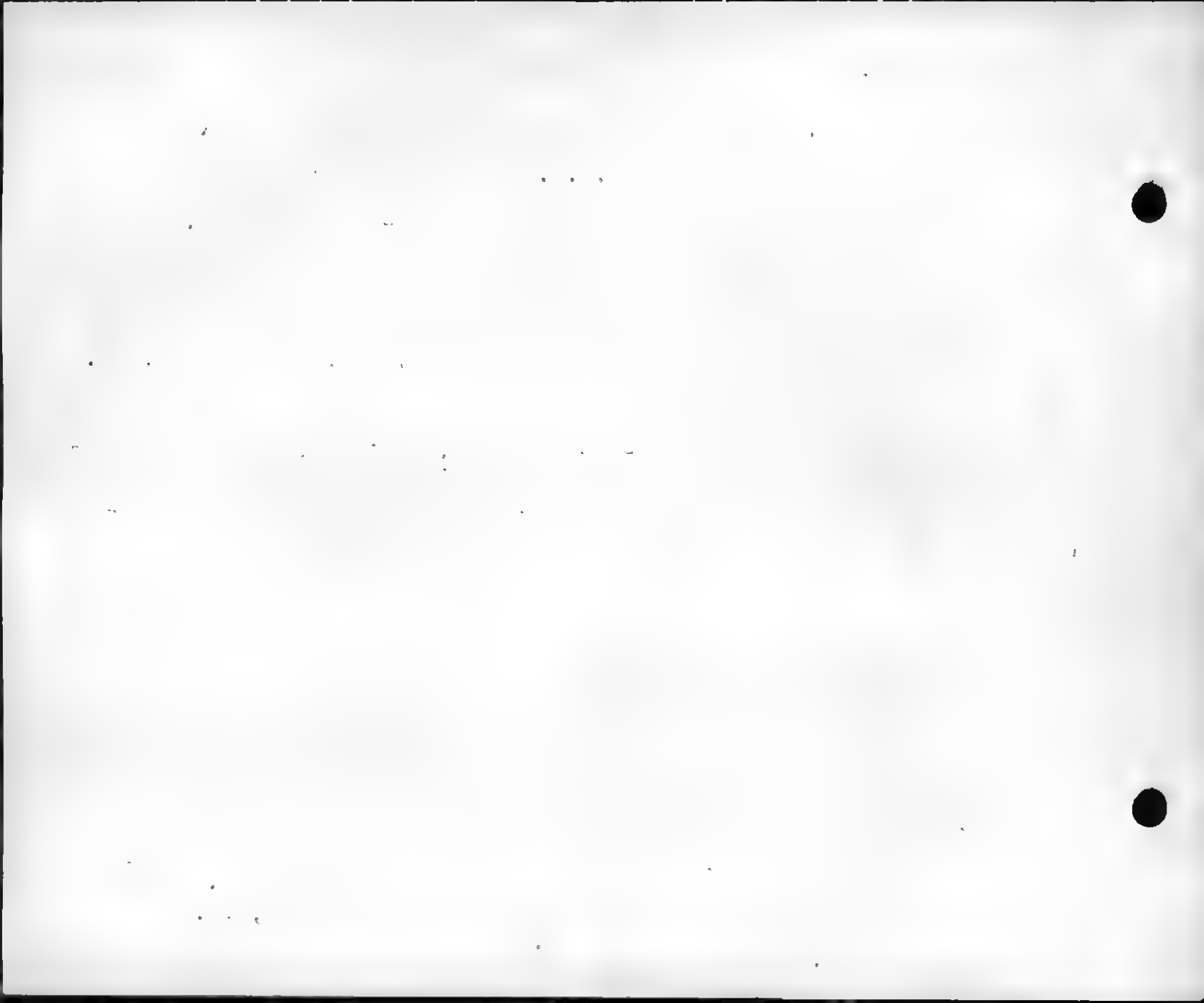
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15881

CERTIFICATE OF DEATH

15872

1. PLACE OF DEATH a. COUNTY Prince Geo. MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland c. COUNTY Montgomery ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 1011-East West Hwy.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence Bailey Lipscomb			4. DATE OF DEATH Month Day Year November 4 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/16/1912	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Mechanic		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Wash., D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S. Am			13. FATHER'S NAME Theodric Lipscomb		
14. MOTHER'S MAIDEN NAME Mary Hogan			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		
16. SOCIAL SECURITY NO. 578-10-5445			17. INFORMANT Mrs. Lillian M. Lipscomb (above address) (Wife)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anteriosclerotic Heart Disease 1 yr. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 5 weeks
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 24, 1967, to Nov. 4, 1967, that (I) (we) last saw the deceased alive on Nov. 3, 1967, and that death occurred at 1:10 P.M., from causes and on the date stated above.					
22a. SIGNATURE Charles C. Hageage M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Charles C. Hageage			22d. ADDRESS 3308 - Perry St., Mt. Rainier, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/8/67	23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.	23d. LOCATION (City or town) Wash., D.C.	(County)	(State)
24. FUNERAL DIRECTOR Valley's Funeral Home Inc.			ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR DATE NOV 9 1967
25b. REGISTRAR'S SIGNATURE Charles Judge					



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

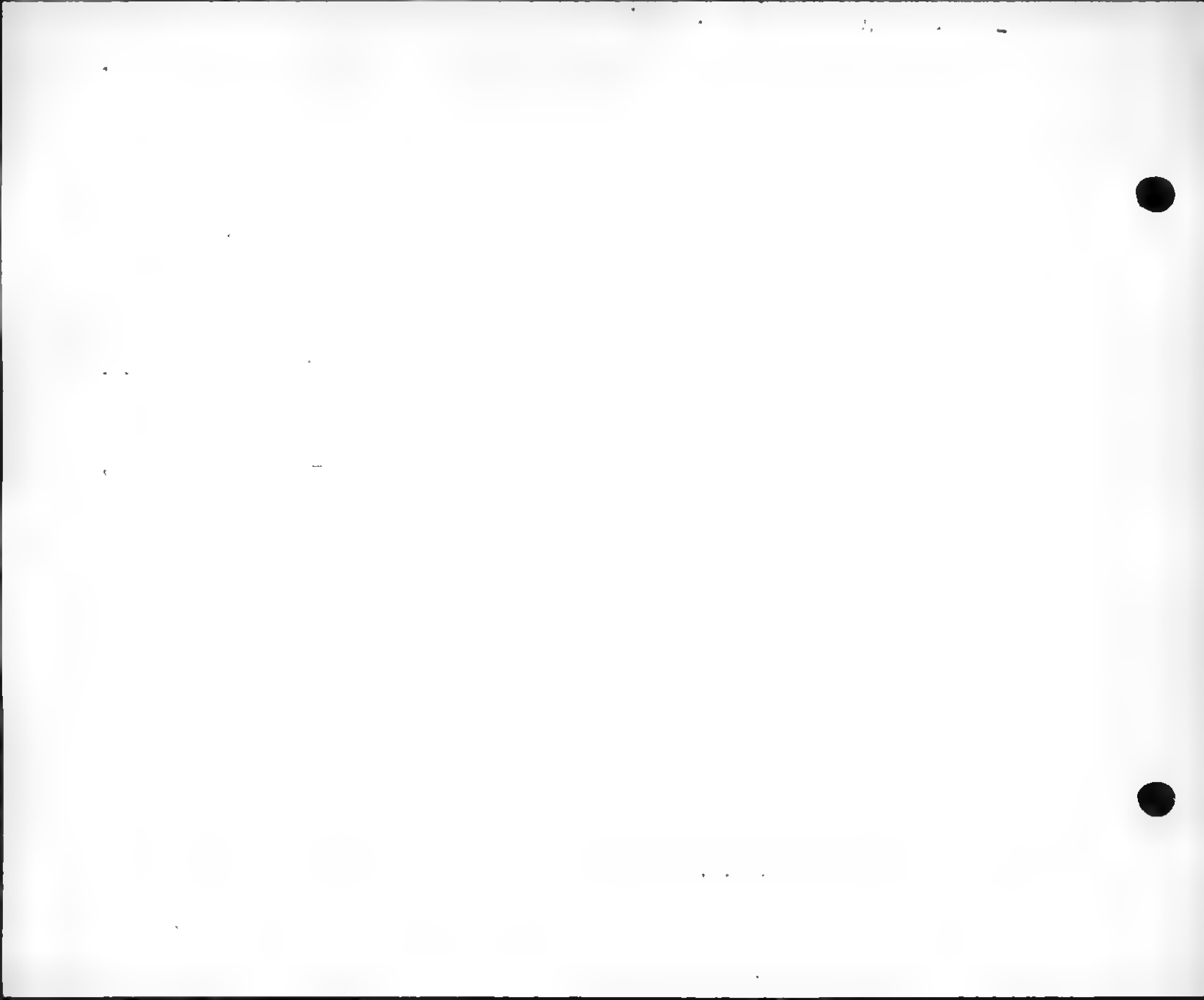
15273

15882

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Pages 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>District of Columbia</u> b COUNTY <u>Washington</u> ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c LENGTH OF STAY IN 1b <u>DOA</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		d STREET ADDRESS <u>1018 Florida Ave., N.E.</u>	
3 NAME OF DECEASED (Type or print) <u>Abraham Locke</u>		4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-14-1914</u>
9 AGE (In years lost b th y) <u>53</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>7</u> Hours <u>19</u> Min <u>67</u>	
10a USUAL OCCUPATION (Give kind of work done during most of life, even if retired) <u>LABORER</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>FEBRUARY 14, 1914</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JESSE LOCKE</u>		14 MOTHER'S MAIDEN NAME <u>AMELIA COX</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17 INFORMANT <u>Mr. Archie Locke - 1018 Florida Ave., N.E.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Alcoholism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Exposure to cold</u> DUE TO (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>11-9-67</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-15-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>		23d. LOCATION (City or Town) (County) (State) <u>Smithland, Md.</u>	
24. FUNERAL DIRECTOR <u>John T. Rhinard</u>		ADDRESS	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>NOV 13 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

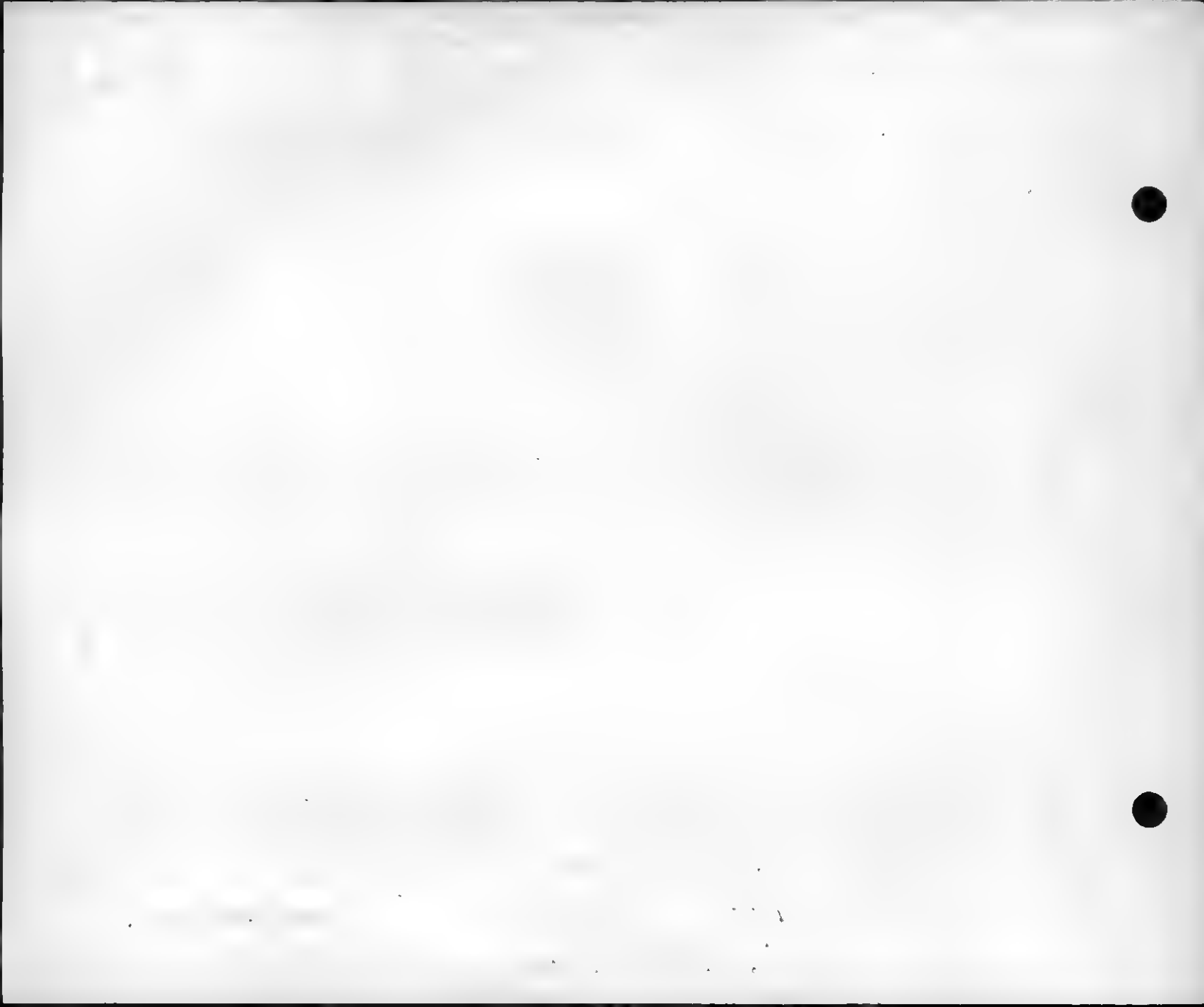
15883

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15874

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MALCOLM GROW USAF HOSPITAL		d. STREET ADDRESS 5204 CANTERBURY WAY	
3 NAME OF DECEASED (Type or print) First Middle Last WILLIAM GEORGE LOONEY		4 DATE OF DEATH Month Day Year NOVEMBER 2 1967	
5. SEX MALE	6. COLOR OR RACE CAU	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 27 Oct 1922
9 AGE (In years lost birthday) 45 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF	
10b. KIND OF BUSINESS OR INDUSTRY USAF		11 BIRTHPLACE (County & State, or foreign country) NEW HAVEN, CONN.	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME WILLIAM CHARLES LOONEY	
14 MOTHER'S MAIDEN NAME MARY BURRAGE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES Jul 42-Jul 63	
16 SOCIAL SECURITY NO 017-14-5424		17. INFORMANT WIFE SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Gastrointestinal hemorrhage (stroke induced)</i> 241X DUE TO (b) <i>Asthma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <i>Acute Myocardial infarction and pulmonary embolism</i> DUE TO (c) <i>1 month</i>		INTERVAL BETWEEN ONSET AND DEATH 12 hours years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>XX</del> this hospital attended the deceased from <u>8 Oct</u> , 1967, to <u>2 Nov</u> , 1967, that <del>XX</del> (we) last saw the deceased alive on <u>2 NOVEMBER</u> , 1967, and that death occurred at <u>1:20 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <i>Allen D. Ward</i>		22b. DATE SIGNED 2 Nov 67	
22c. PHYSICIAN'S NAME (Type) ALLEN D. WARD, CAPT, USAF, MC		22d. ADDRESS Malcolm Grow USAF Hospital Andrews AFB, Wash., D.C. 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/6/67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEMETERY	23d. LOCATION (City or town) (County) (State) ARLINGTON, VIRGINIA
24 FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND		25a. REC'D BY REGISTRAR DATE NOV 7 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			





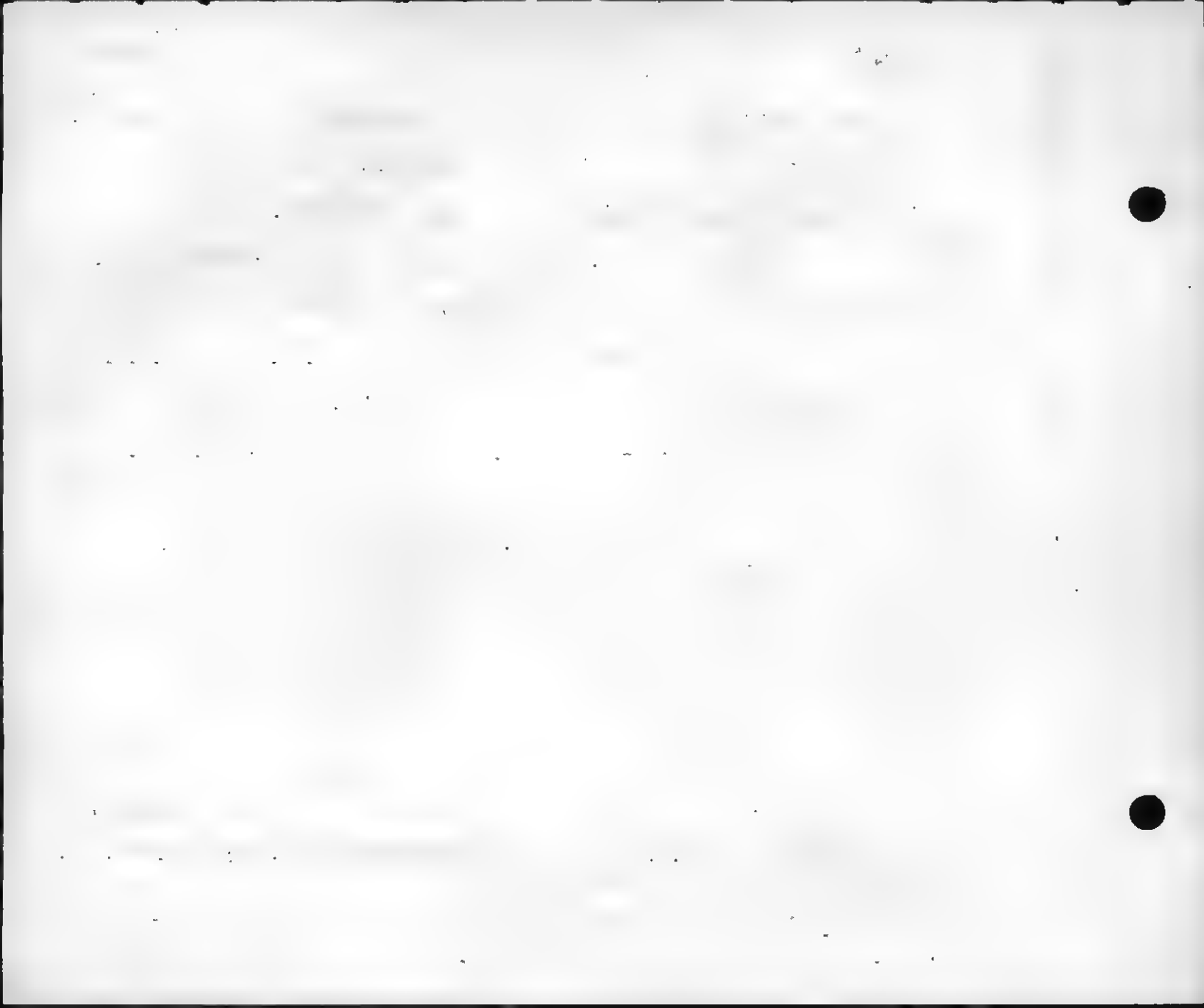
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN Ib <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> d. STREET ADDRESS <b>6018 Mustang Dr.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Susie</b> Middle <b>Augusta</b> Last <b>Love</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>11</b> Year <b>1967</b>		<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>5/12/82</b>		<b>9. AGE</b> (In years last birthday) <b>85</b> yrs. IF UNDER 1 YEAR: Months <b>11</b> Days <b>19</b> Hours <b>67</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D. C.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Andrew Hoskins</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Catherine Jemnyson</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>219-54-9649</b>		<b>17. INFORMANT</b> <b>Mrs. Naomi Houghton</b> <b>6018 Mustang Drive Riverdale, Md.</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Cardiac arrest</b> <b>DUE TO (b)</b> <b>Arteriosclerotic cardiovascular disease</b> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <b>none</b> <b>(c)</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>26 yrs.</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> to <u>11/11</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>11/11</u>, 19<u>67</u>, and that death occurred at <u>11:00 PM</u> from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <b>Peter Duus</b>						<b>M.D. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>11/11/67</b>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Peter Duus, M.D.</b>						<b>22d. ADDRESS</b> <b>6124 Central Ave., Capitol Hgts., Md. 20027</b>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>Nov. 14, 1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Glenwood Cemetery</b>			<b>23d. LOCATION (City, town or county) (State)</b> <b>Washington, D. C.</b>					
<b>24. FUNERAL DIRECTOR</b> <b>Glen Carter</b> <b>Warner E. Pumphrey, Inc.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>NOV 17 1967</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>					



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
 Items 13 & 17 *File 6397 2/1/68*

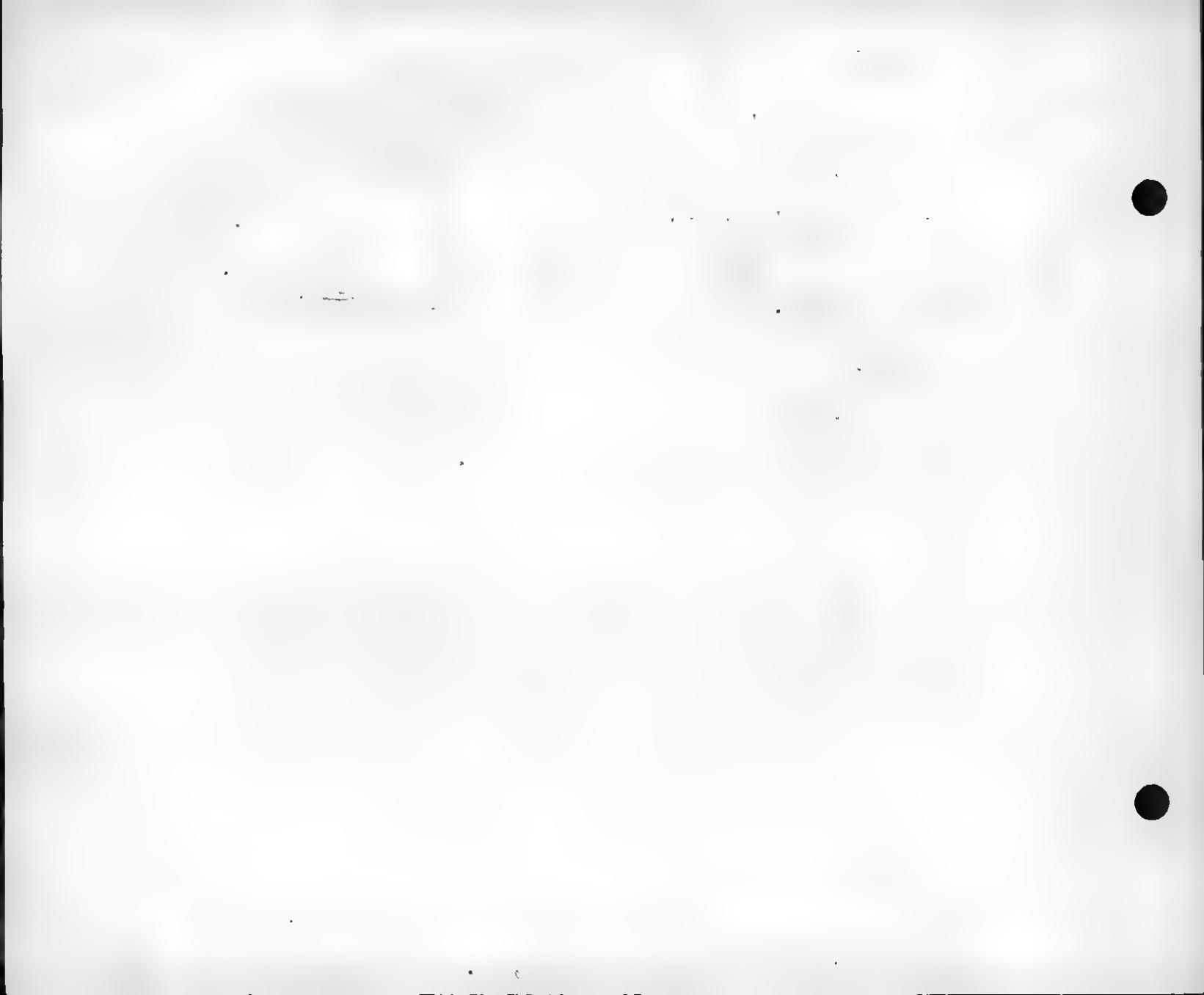
15885

**CERTIFICATE OF DEATH**

15876

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Canada</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN TB <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Toronto</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>1520 Danforth Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Daisy Maginn</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>21</b> Year <b>19 68</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>***1933* 3-12-89</b>		9. AGE (in years last birthday) <b>88</b> YES <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>England</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Canada</b>			13. FATHER'S NAME <b>Benjamin W. Maginn</b>		
14. MOTHER'S MAIDEN NAME <b>Anna Garner</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Gladys Mrs. May Broom (daughter)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CA OF RT LUNG. RLL</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 13, 1967</b> , to <b>Nov 21, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Nov 21, 1967</b> , and that death occurred at <b>4:40 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <i>[Signature]</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>11-21-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>Pine Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Toronto Canada</b>		
24. FUNERAL DIRECTOR <b>Washington Metropolitan Funeral Service</b>		ADDRESS <b>Box 1195 Falls Church, Va.</b>		25a. REC'D BY REGISTRAR <b>NOV 24 1967</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

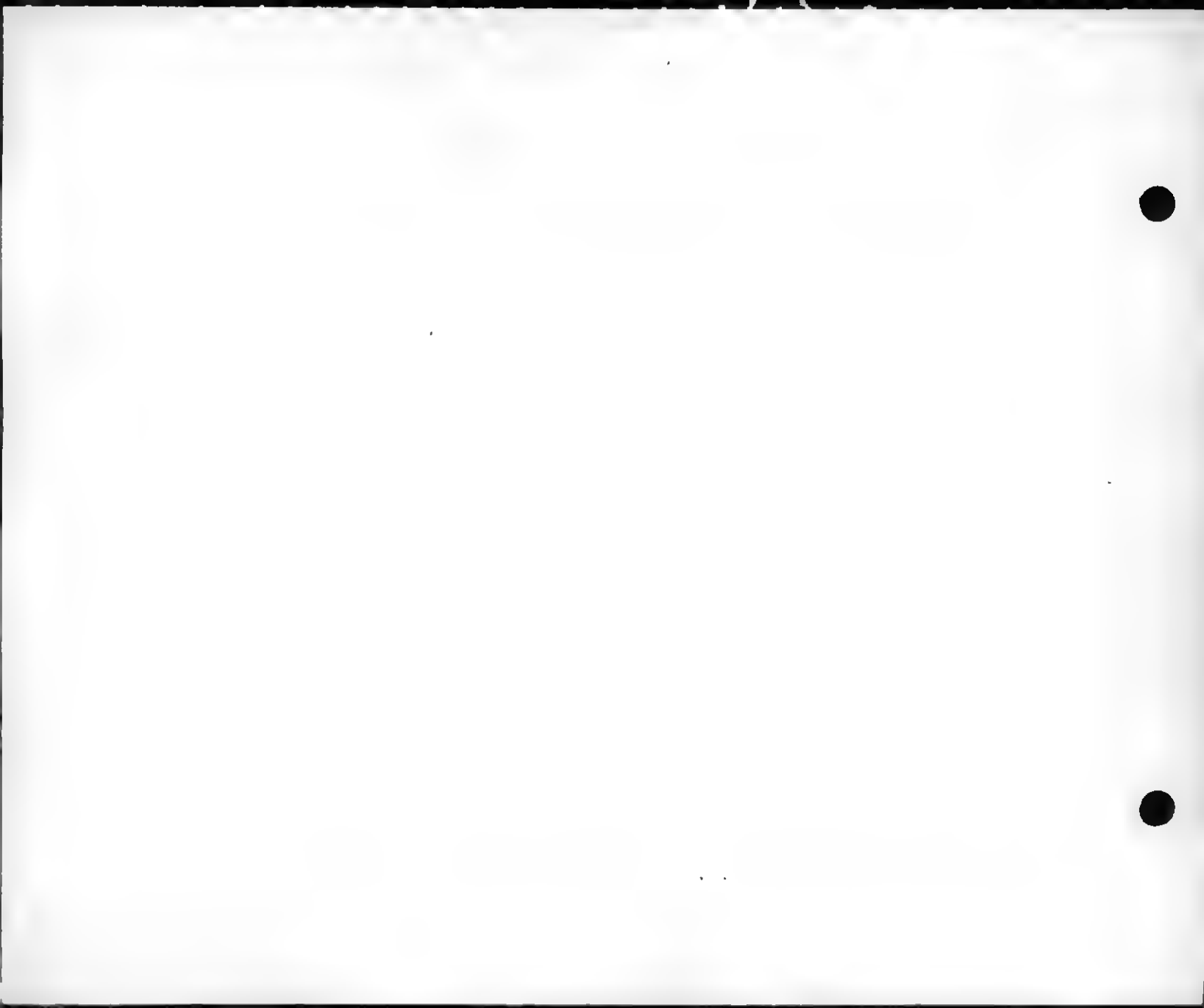
VR A15ME (5) 4 2  
6M 1/66

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 11, 12, 13 & 14 Film G39, 11/21/67 RA

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchelville</b>		c. LENGTH OF STAY IN 1b <b>Mitchelville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 1050 Woodmore Road</b>		d. STREET ADDRESS <b>Box 1050 Woodmore Road</b>	
3 NAME OF DECEASED (Type or print) <b>Wallace</b>		4 DATE OF DEATH Month <b>11</b> Day <b>11</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>20 Jan. 1933</b>
9 AGE (In years last birthday) yrs <b>34</b>		10 IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Curtis Marshall</b>		14 MOTHER'S MAIDEN NAME <b>Nettie Hawkins</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> DUE TO <b>Volvulus of cecum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>11-13-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>11-15-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Family</b>		23d. LOCATION (City or town) (County) (State) <b>Woodmore Md</b>	
24. FUNERAL DIRECTOR <b>Rollins F. Home</b>		25a. REC'D BY REGISTRAR <b>4339-Amt PLH</b>	
25b. REGISTRAR'S SIGNATURE <b>Rollins F. Home</b>		25c. DATE <b>NOV 16 1967</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

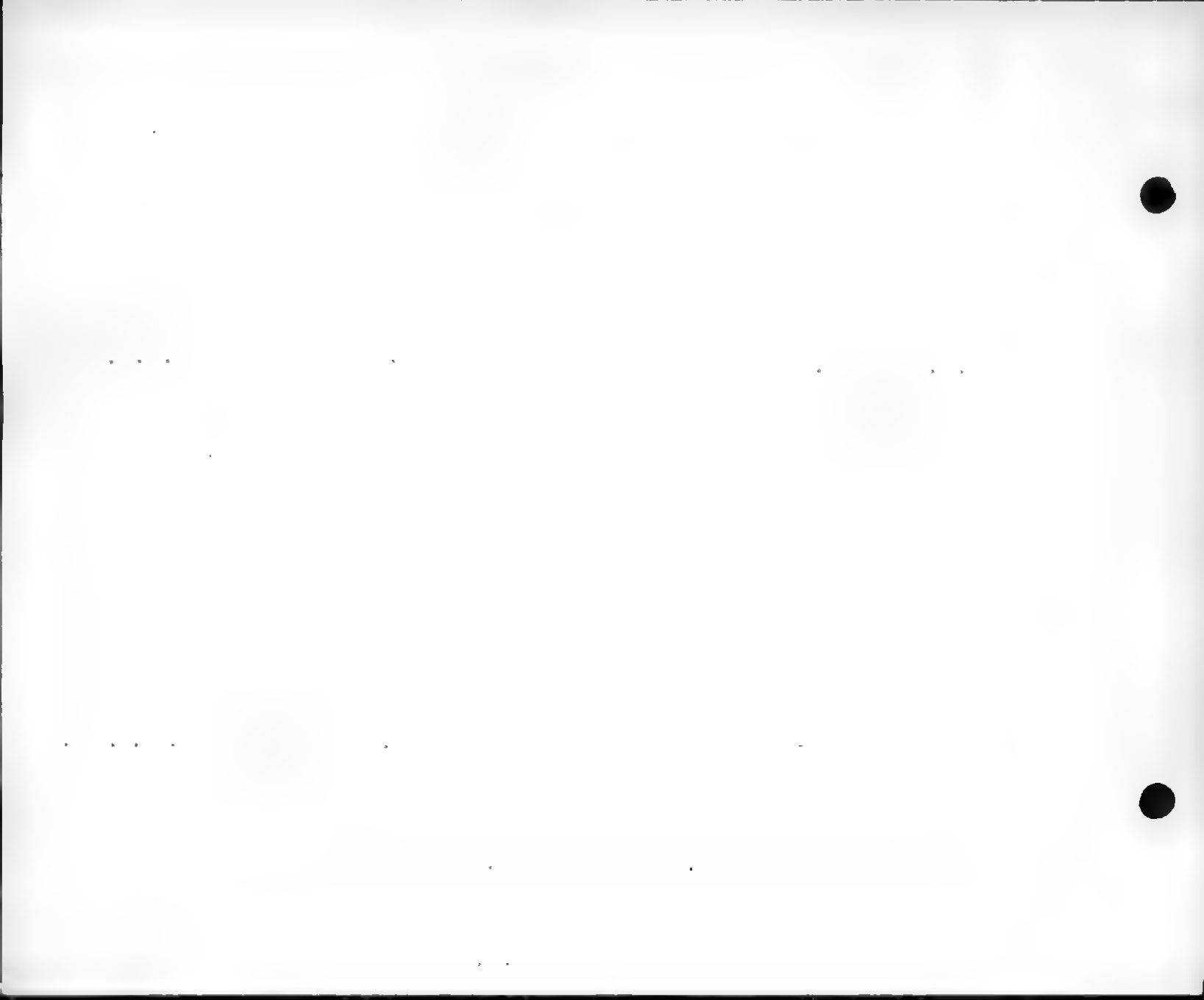
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15887

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15878

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		a. STREET ADDRESS <b>8555 Glen Dale Road</b>	
3 NAME OF DECEASED (Type or print) First <b>Laurie</b> Middle <b>C</b> Last <b>Martin</b>		4. DATE OF DEATH Month <b>11</b> Day <b>8</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 1, 1908</b>
9 AGE (In years last birthday) <b>59</b>		10 FUNDING YEAR Months <b>11</b> Days <b>8</b> Hours <b>19</b> Min. <b>67</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.C.A. Corp.</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Topeka, Kansas</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clarence H. Martin</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Antoinette Stanton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Mr. Baker</b>		Address <b>El Paso, Texas</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> <b>104</b> DUE TO <b>Trauma auto accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Driver of car involved in collision</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>5:00pm</b> <b>11-8-1967</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Old Calvert Rd. &amp; Kenilworth Ave. P.G. Co.</b>		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>11-9-67</b>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
<b>removal</b>	<b>11/10/67</b>	<b>Ft. Bliss National Cem.</b>	<b>El Paso, Texas</b>
24 FUNERAL DIRECTOR <b>The S.H. Hines Company</b>		25a REC'D BY REGISTRAR <b>NOV 10 1967</b>	
Address <b>2901 14th St. N.W. Washington, D.C.</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1-2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME  
6M 1/66

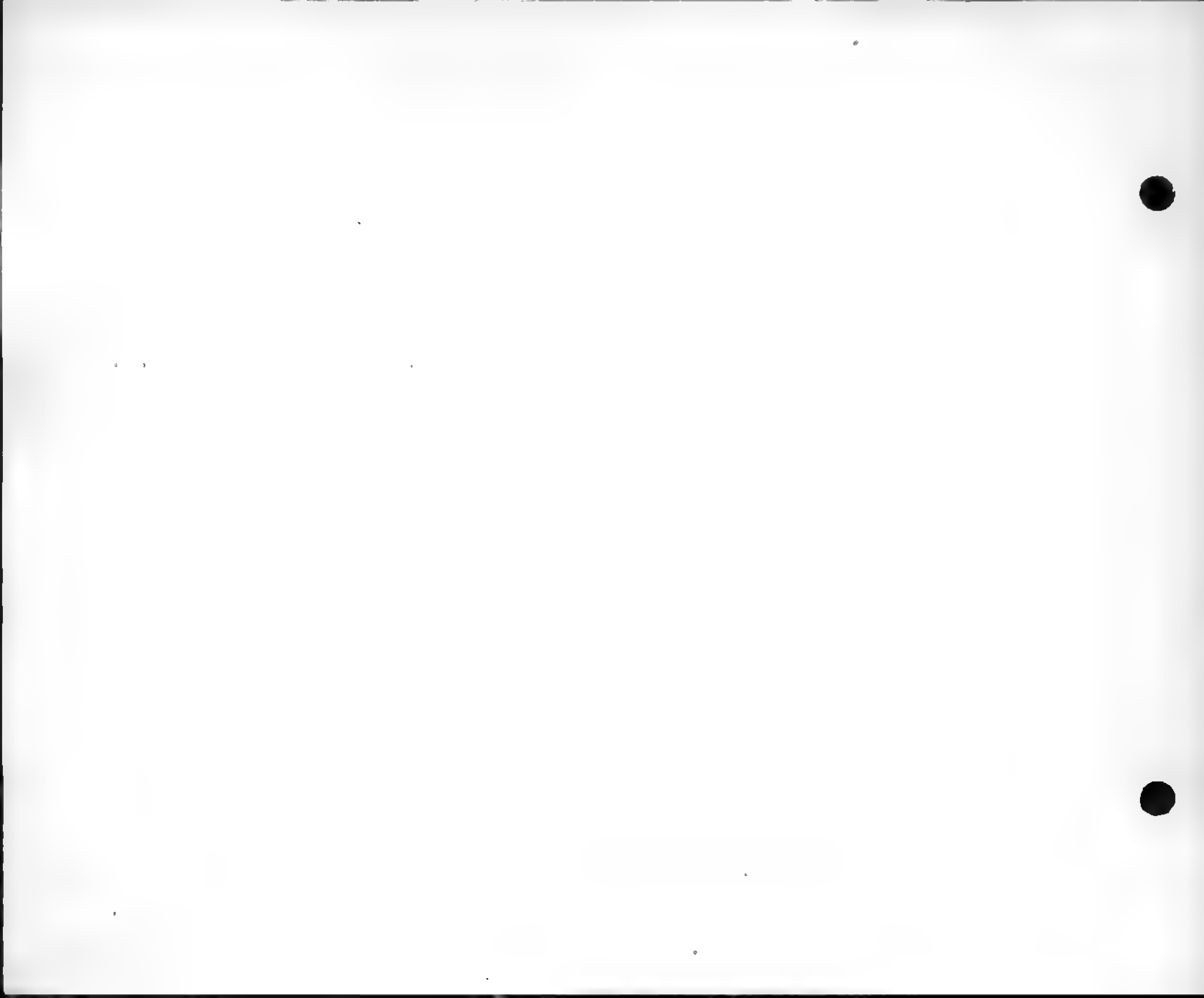
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15888

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15979

1. PLACE OF DEATH a COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b DOA		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d STREET ADDRESS 3612 41st Avenue		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Larry Peter Mayola				4. DATE OF DEATH Month Day Year 11 6 19 67			
5. SEX male	6. CO. OR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-7	9. AGE (In years last birthday) 65 yrs	F UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Mayola				14. MOTHER'S MAIDEN NAME Maria Kelly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO -		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Ulceration of multiple Hemangiomas of oesophagus DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 11-6-67			
23a. BURIAL, CREMATION, REMOVAL (Type)	23b. DATE THEREOF 11/9/67	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.			
24. FUNERAL DIRECTOR Maryland Home Inc.		25a. REC'D BY REGISTRAR DATE NOV 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

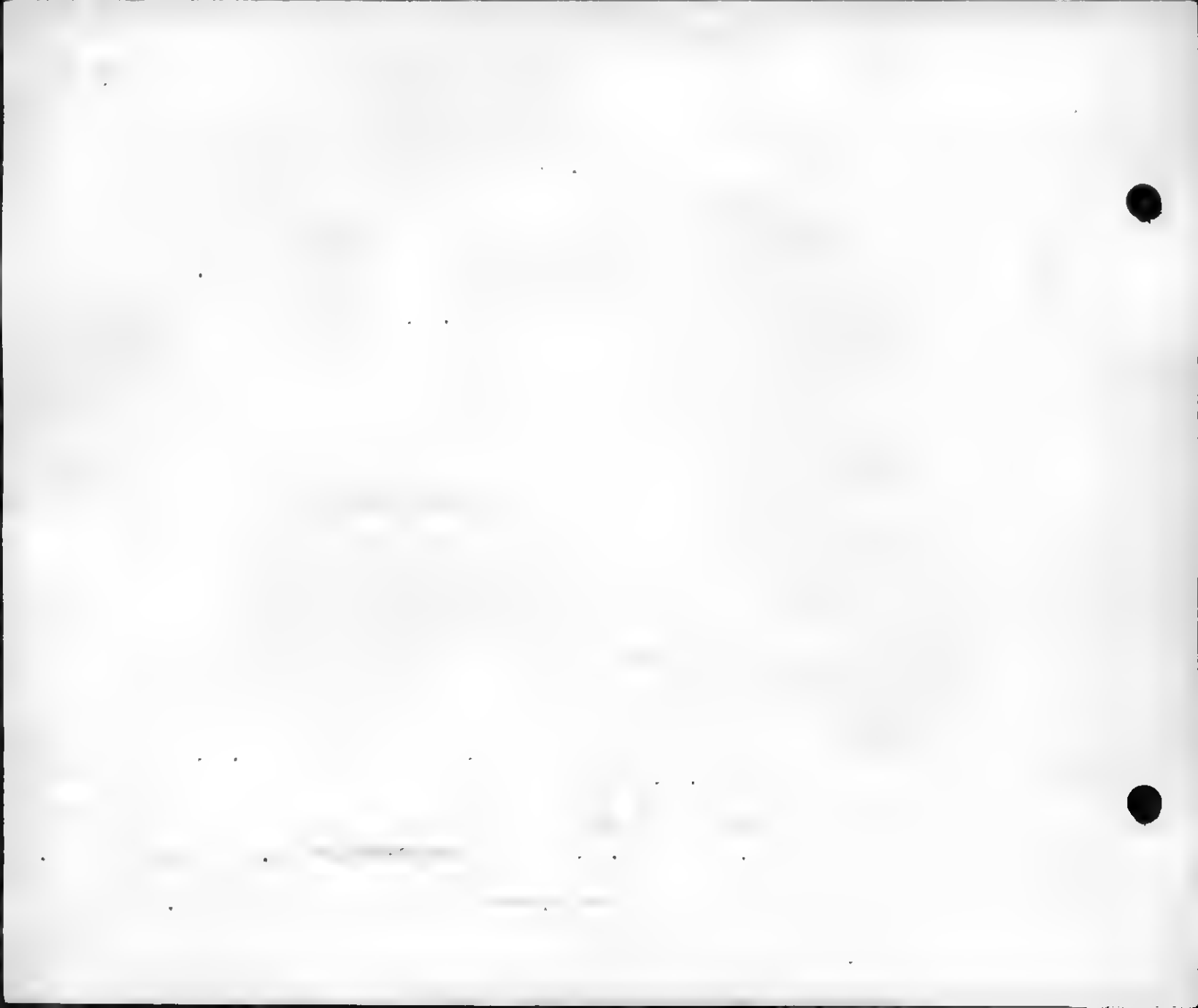
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #11 infor, taken from birth cert. ph

CERTIFICATE OF DEATH

15885

15880

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>8 hrs. 10mins</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>225 Lakeside Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Girl "B" McCulloch</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>5.</b> Year <b>19 67</b>		5. SEX <b>Female</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 5, 1967</b>	
9. AGE (In years last birthday) yrs. <b>8</b> Months <b>10</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Cheverly, P.G. Co.</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Robert Zell McCulloch</b>	
14. MOTHER'S MAIDEN NAME <b>Lenna Edith Lawrence</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atelectasis of lungs. bilateral</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>less than 1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>Nov. 5, 1967</b> to <b>Nov. 5, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Nov. 5, 1967</b> , and that death occurred at <b>5:55 PM</b> , from causes and on the date stated above	
22a. SIGNATURE <b>Andrew G. Aronfy</b> M.D.		22b. DATE SIGNED <b>11-5-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Andrew G. Aronfy, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>11-11-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General</b>	
23d. LOCATION (City or Town) (County) (State) <b>Cheverly, Md.</b>		24. FUNERAL DIRECTOR <b>William A. Parker</b> Cheverly, Md.		25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. REGISTRAR'S NAME <b>[Signature]</b>		25d. REGISTRAR'S ADDRESS	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia, Washington b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b Two months		d. STREET ADDRESS 2101- 16th Street, N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Helen J. McGolrick		4. DATE OF DEATH Month Day Year November 18 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1889
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Richard Purcell		14. MOTHER'S MAIDEN NAME Mary McCabe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no None		16. SOCIAL SECURITY NO 579-44-9640	
17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from SEPT 18, 1967, to NOV 18, 1967, that (I) (we) last saw the deceased alive on NOV 17, 1967, and that death occurred at 1:05 A.M. from causes and on the date stated above.			
22a. SIGNATURE Paul A. DeVore M.D.		22b. DATE SIGNED NOV 18, 1967	
22c. PHYSICIAN'S NAME (Type) PAUL A. DEVORE, M.D.		22d. ADDRESS 3415 HAMILTON ST Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/21/67	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATL	23d. LOCATION (City or Town) (County) (State) SWITLAND, PR GEO CO, MD.
24. FUNERAL DIRECTOR W. W. Hamberline 1400 Chapel St. N.W.		25a. REC'D BY REGISTRAR DATE NOV 21 1967	
		25b. REGISTRAR'S SIGNATURE	



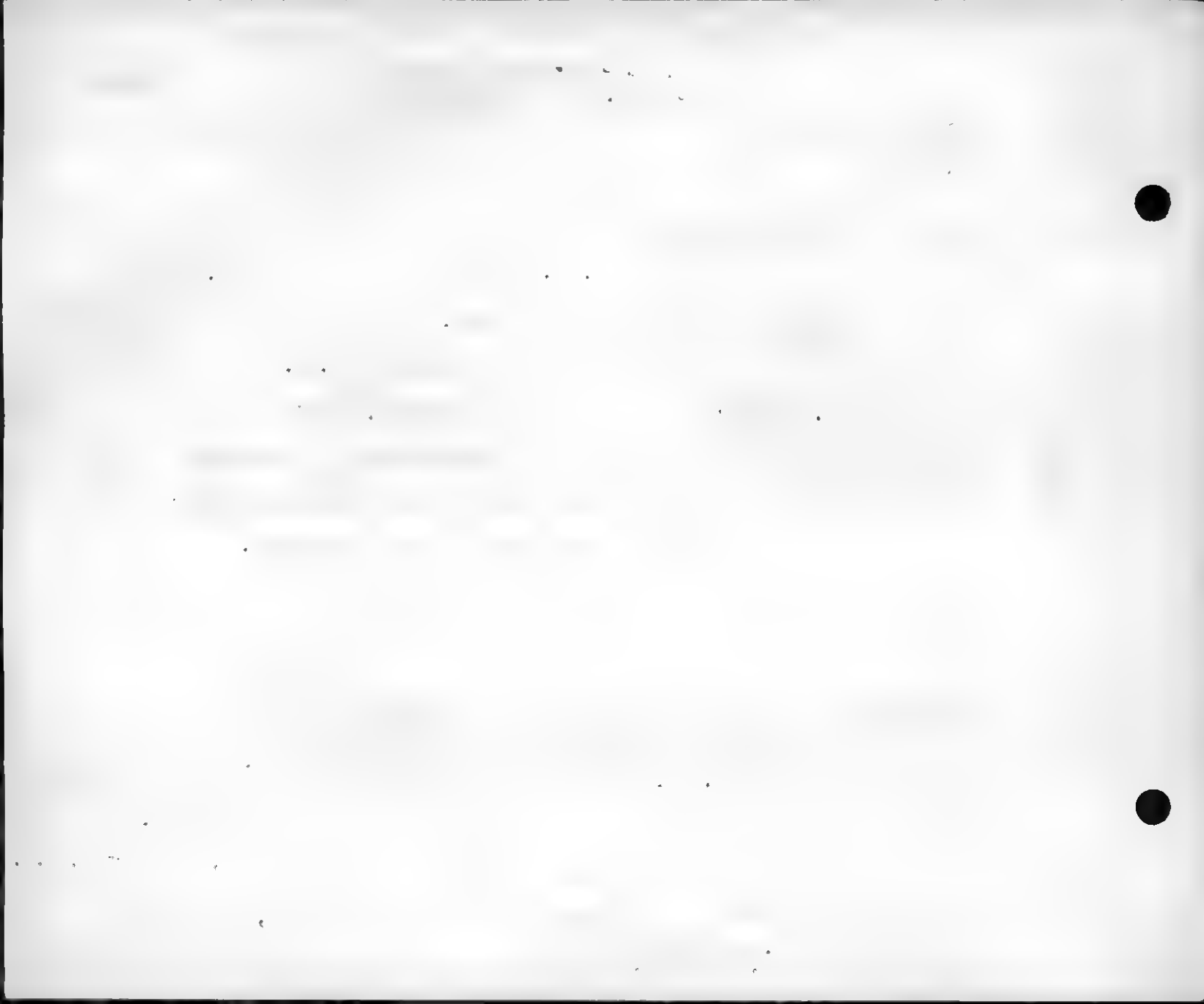
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

10082

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>3 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District Heights</b>			d. STREET ADDRESS <b>7422 Marbury Drive</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mark XX J. McNally</b>		4. DATE OF DEATH Month Day Year <b>Nov. 23. 19 67</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>Nov. 4, 1967</b>		9. AGE (In years last birthday) yrs <b>19</b>		IF UNDER 1 YEAR Months Days Hours Min <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NA</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NA</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William P. McNally</b>				14. MOTHER'S MAIDEN NAME <b>Susan C. Martin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>William McNally Same As #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple acute gastric ulcers with hemorrhage;</b> <b>7640</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute pseudo-membraneous enterocolitis.</b> DUE TO (c) <b>2 days</b>							INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>was present</del> ) attended the deceased from _____, 19____, to <b>Nov. 23, 1967</b> , that (I) ( <del>was</del> ) saw the deceased alive on <b>Nov. 23, 1967</b> , and that death occurred at <b>4:25AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Kelvin Minchin</i>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 24, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Kelvin Minchin, M.D.</b>				22d. ADDRESS <b>6400 Marlboro Pike, SE, Washington, D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/25/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Clinton, PG Maryland</b>	
24. FUNERAL DIRECTOR <b>ROBERT E. WILHELM FUNERAL HOME</b> <b>4308 SUTLAND ROAD, SUTLAND, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>NOV 30 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

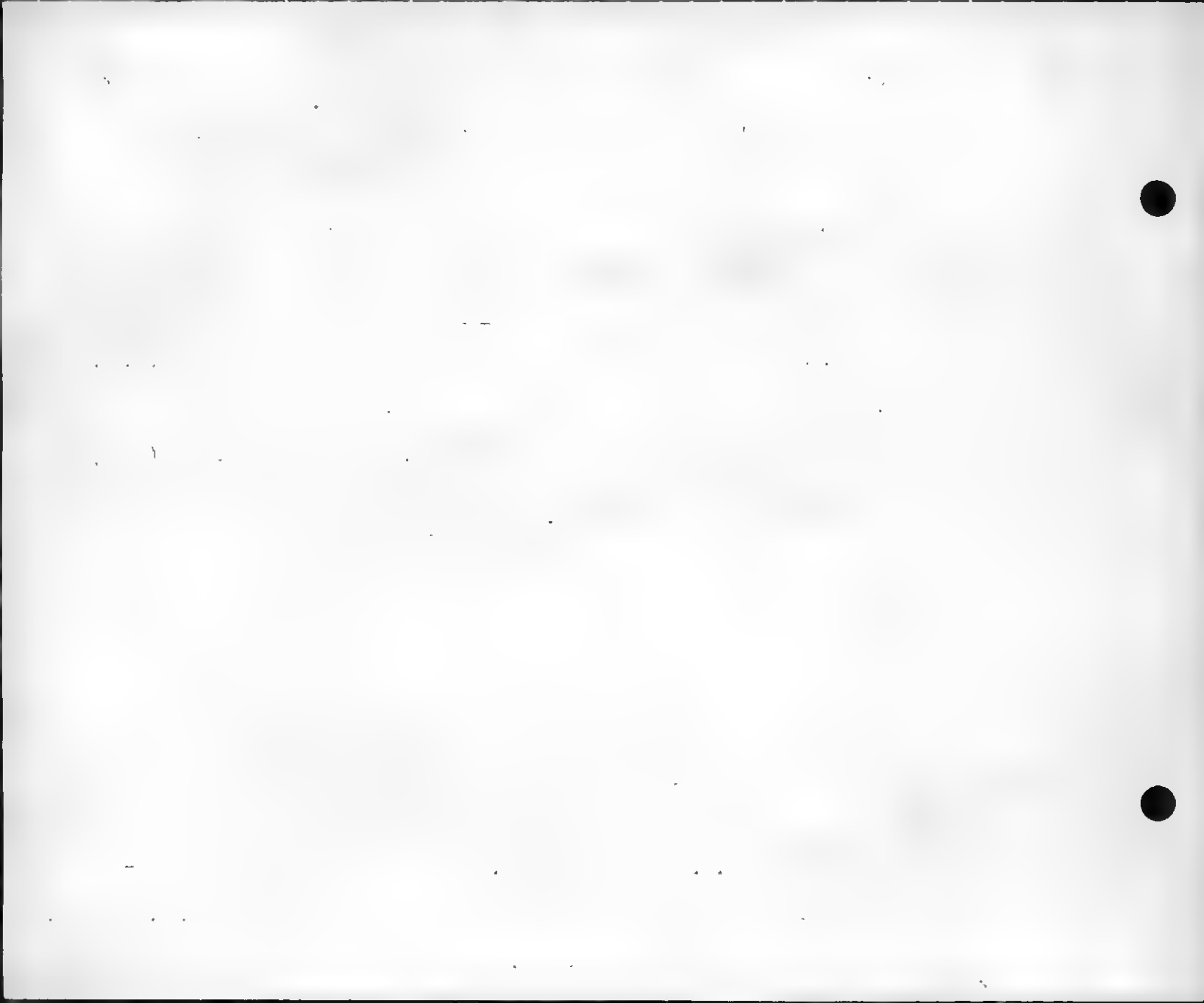
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15891

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15883

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		d. STREET ADDRESS <b>3602 Hamilton Street</b>	
3 NAME OF DECEASED (Type or print) First <b>Norman</b> Middle <b>Henry</b> Last <b>Mihill</b>		4 DATE OF DEATH Month <b>11</b> Day <b>19</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8-2-1917</b>
9 AGE (In years last birthday) <b>50</b> yrs		10 IF UNDER 1 YEAR Months <b>11</b> Days <b>19</b> Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during week ending on the day of death) <b>Radio &amp; T.V. Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>	
11 BIRTHPLACE (State or foreign country) <b>New York</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Roy E. Mihill</b>		14. MOTHER'S MAIDEN NAME <b>Lila M. Hewitt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <b>no</b> unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>578 05 5623</b>	
17 INFORMANT <b>Blanche E. Mihill Same as #2 (wife)</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>11-20-67.</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/22/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>	23d. LOCATION (City or town) (County) (State) <b>Hyattsville P.G. Md.</b>
24 FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>NOV 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

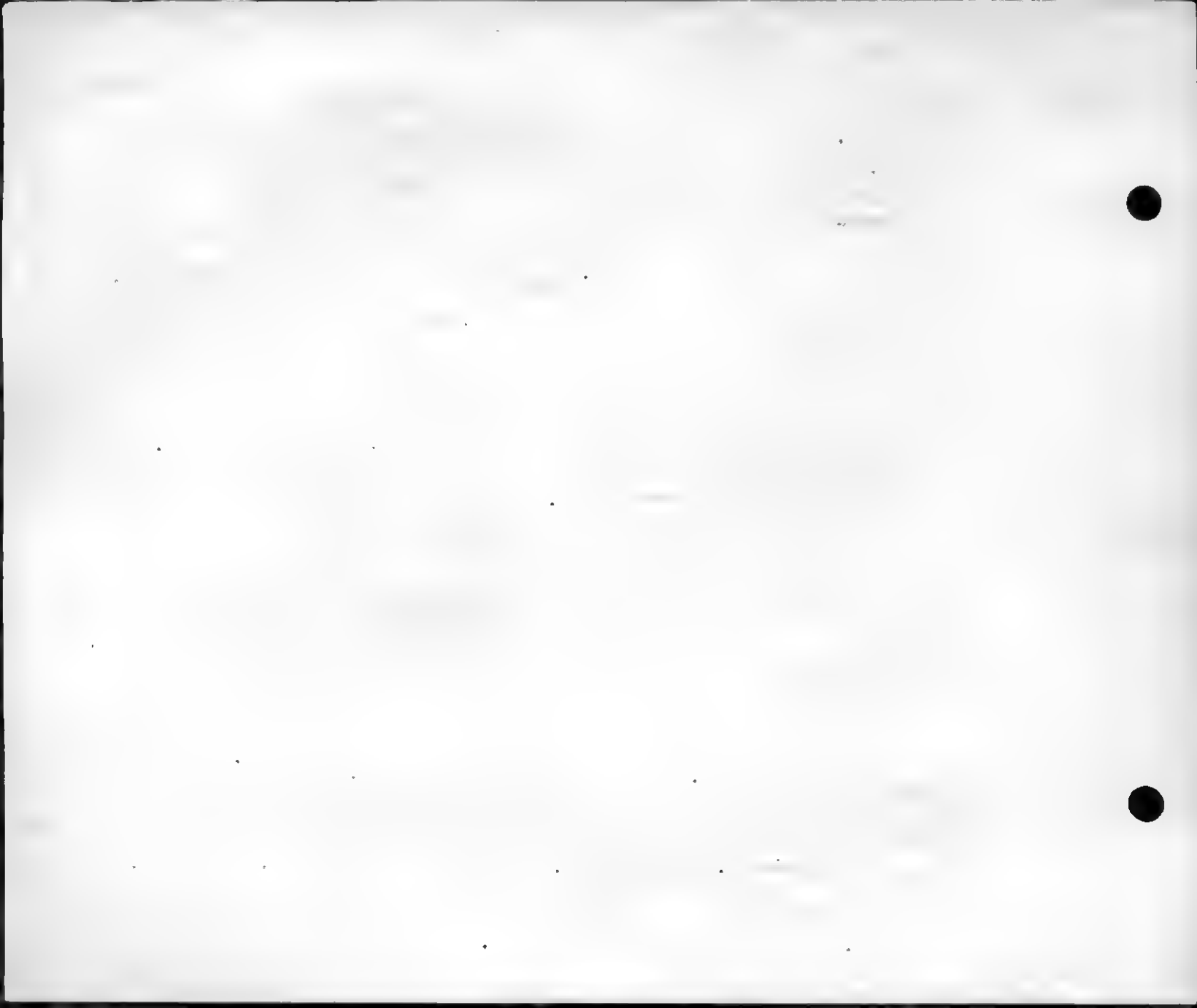
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>16 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>6124 Breeswood Drive #201</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Bee A. Moores</b>		4 DATE OF DEATH Month Day Year <b>November 21, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/6/81</b>
9. AGE (In years lost birthday) <b>86 yrs</b>		10. IF UNDER 1 YEAR* IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>church</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Texas</b>		12 CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Alex Moores</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Ashby</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>219 54 8045</b>	
17. INFORMANT <b>Mollie E Moores</b>		Address <b>Greenbelt, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Undetermined.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Sept. 19, 67</b> to <b>Nov. 21, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Nov. 21, 1967</b> , and that death occurred at <b>2:05 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <i>William C. Weintraub</i>		22b. DATE SIGNED <b>Nov. 22, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>William C. Weintraub, M. D.</b>		22d. ADDRESS <b>Professional Bldg., Greenbelt, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 24, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <i>Orlando J. Jaffer</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15893

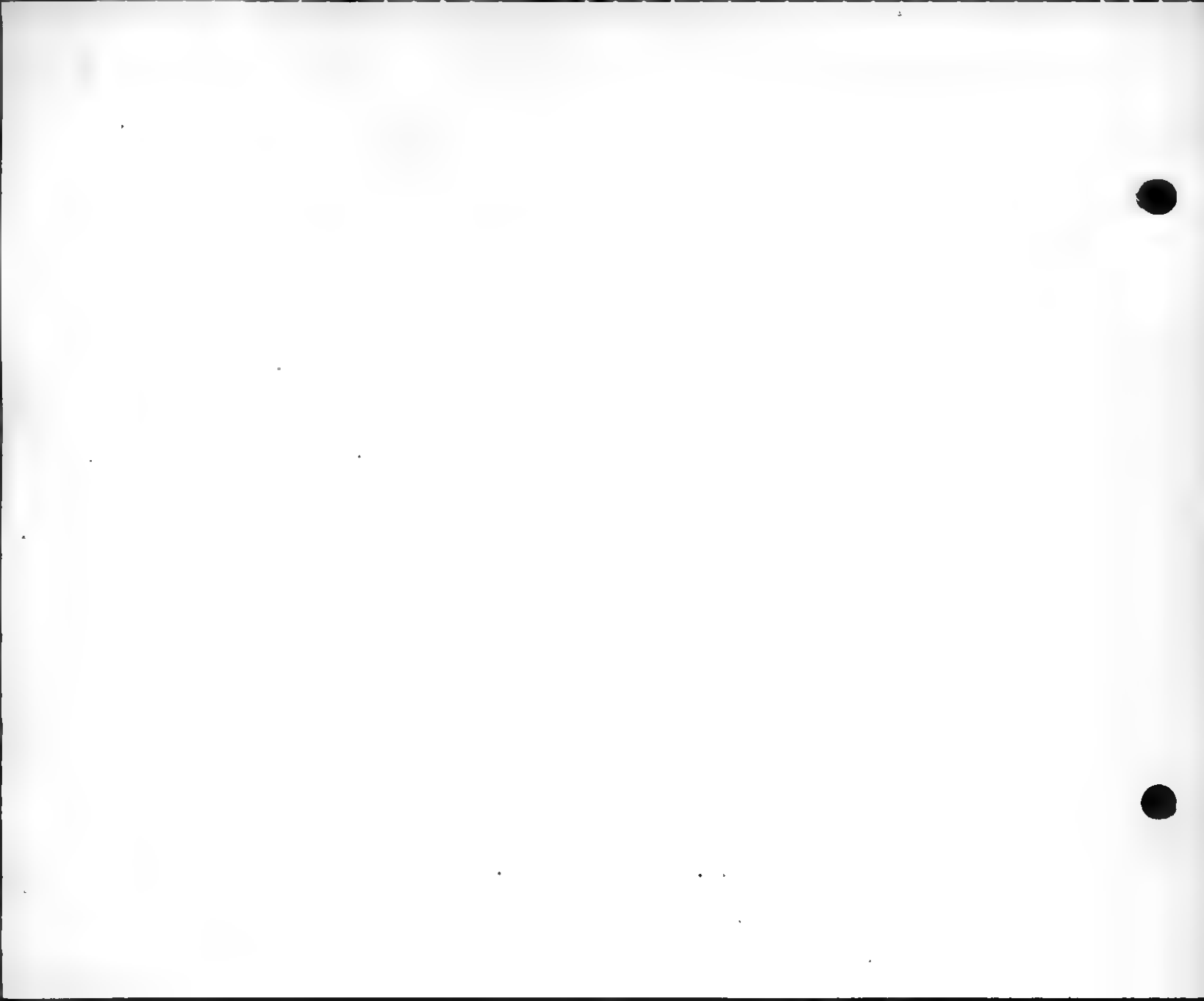
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15885

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN Id <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Michael David Morgan</b>		4. DATE OF DEATH <b>11 13 19 67</b>	
5. SEX <b>Male</b>	6. CO. OR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 April 1944</b>
9. AGE (In years last birthday) <b>23</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>David B Morgan</b>		14. MOTHER'S MAIDEN NAME <b>Jessie P. Proctor</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>--</b>	
17. INFORMANT <b>David B Morgan</b>		Address <b>Berwyn Heights, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>1771</b> DUE TO <b>Muscular dystrophy</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>over 20 yrs.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>11-14-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 16, 1967</b>	23c. NAME OF CEMETERY OR REMOVAL <b>Arlington National</b>	23d. LOCATION (City or town) (County) (State) <b>Arlington Virginia</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 17 1967</b> 25b. REGISTRAR'S SIGNATURE <b>W. Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15894

15896

1 PLACE OF DEATH a. COUNTY <u>Pr. Geo. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 47-3	
c. LENGTH OF STAY IN 1b <u>—</u>		d. STREET ADDRESS <u>#22 3rd. St. S.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>HOWARD F.</u> Middle <u>MULLIGAN</u> Last <u>—</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>11</u> Year <u>1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/29/1898</u>
9 AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. C.T. ZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Patrick E. Mulligan</u>		14. MOTHER'S MAIDEN NAME <u>Anna H. Hughes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>126-18-5682</u>	
17. INFORMANT <u>Robert Mulligan - Casanova N.Y.</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arrhythmia Fibrillation</u> <u>4331</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>to hr. Myocarditis</u> DUE TO (c) <u>Sen. Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>6 mos</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>—</u> 19 <u>67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> to <u>Nov 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 11</u> 19 <u>67</u> and that death occurred at <u>1:00 P.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Walter E. McCawley</u> M.D.		22b. DATE SIGNED <u>Nov 11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER E. McCAWLEY</u>		22d. ADDRESS <u>701 1/2 Con Anse Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/14/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	23d. LOCATION (City or Town) (County) (State) <u>Wt. Vernon D.C.</u>
24. FUNERAL DIRECTOR <u>JAS. T. RYAN, INC. 830 N. 7</u>		25a. REC'D BY REGISTRAR <u>317 PA. AVE S.E. Wash D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Ryan</u>		25c. DATE <u>NOV 15 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





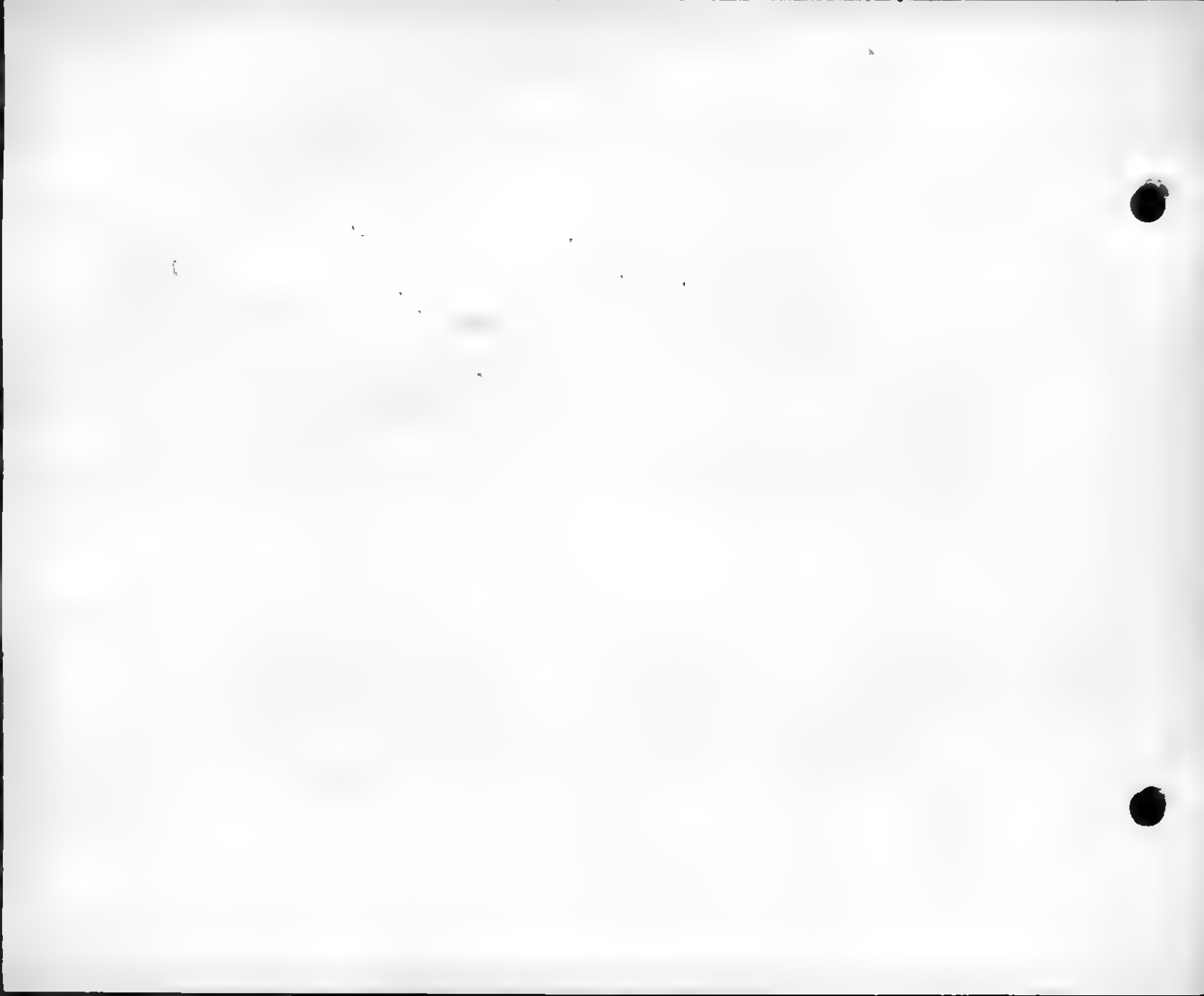
15895

15887

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham, Md.</b> c. LENGTH OF STAY IN b. <b>1</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham, Maryland</b> d. STREET ADDRESS <b>308 Gorman Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Benjamin T. Murphy</b> First Middle Last		4. DATE OF DEATH <b>11/10/67</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/28/96</b> Month Day Year
9. AGE (In years last birthday) <b>71</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Govt</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Scaggsville Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Murphy</b>		14. MOTHER'S MARRIAGE NAME <b>Marion Gates</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>WW 1</b>		16. SOCIAL SECURITY NO <b>579-09-2904</b>	
17. INFORMANT <b>Mrs B. T. Murphy - Ahome</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> DUE TO (b) <b>CARCINOMA OF PANCREAS</b> DUE TO (c) <b>CARCINOMA OF PANCREAS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b> <b>6 MONTH</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-1</b> , 19 <b>67</b> , to <b>11-11</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-10</b> , 19 <b>67</b> , and that death occurred at <b>12:30</b> AM, from causes and on the date stated above.			
22a. SIGNATURE <b>C. J. Houmann</b>		22b. DATE SIGNED <b>11-11-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. J. HOUMANN</b>		22d. ADDRESS <b>RIVERDALE MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-13-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Pauls Lutheran Bultan Md</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>W. Hammond</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 16 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15896

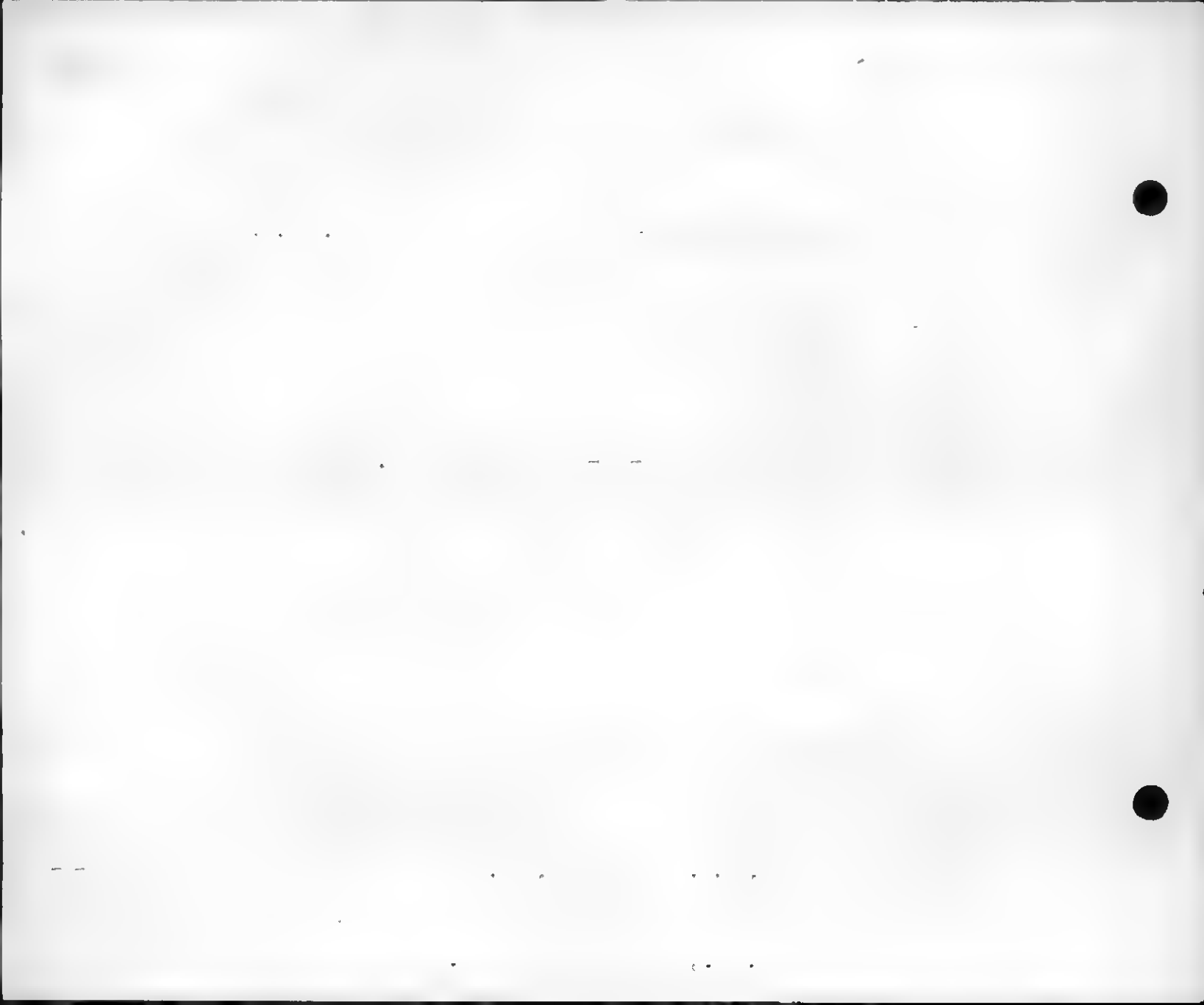
15888

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas Anthony Murphy</b>				4. DATE OF DEATH Month Day Year <b>11 30 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 July 1925</b>	9. AGE (In years last birthday) <b>42</b> yrs	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Traffic Manager</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Edward Murphy</b>				14. MOTHER'S MAIDEN NAME <b>Beatrice Dorian</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes WW II</b>			16. SOCIAL SECURITY NO <b>121-14-1581</b>		17. INFORMANT Address <b>Kathryn B. Murphy same as #2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>Y200</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH. <b>minutes over 2 yrs.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 8)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b>			M.D. <b>John Kehoe, M.D. Riverdale, Md.</b>			22. DATE SIGNED <b>12-1-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>			Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/5/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem. Arlington, Virginia</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR ADDRESS <b>Falls Church F. H., Falls Church, Va.</b>				25a. REC'D BY REGISTRAR <b>DEC 5 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

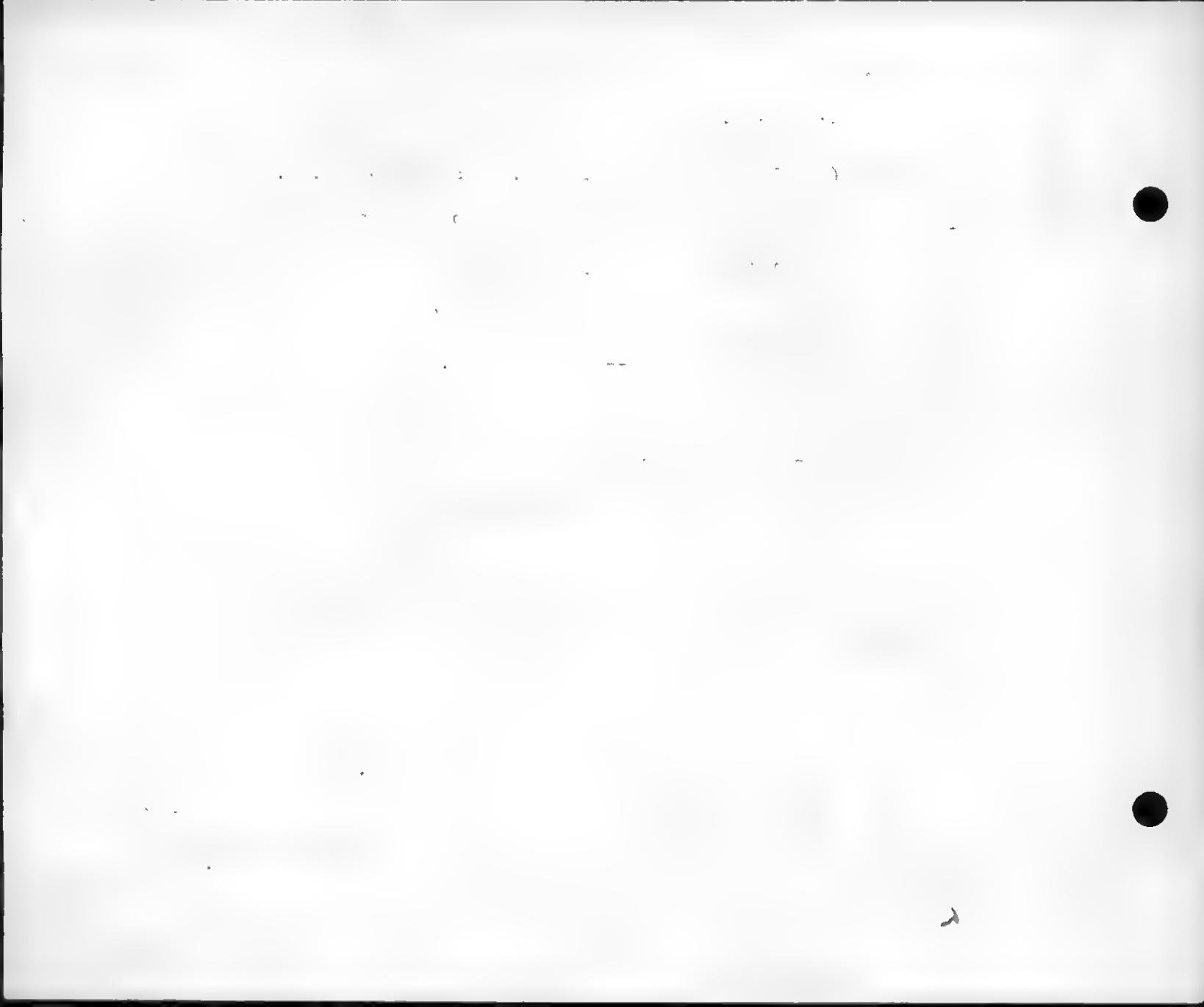
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1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>MARYLAND</b> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c LENGTH OF STAY IN 1b <b>2mos., 2 wks.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>J. P.</b> Last <b>Murphy</b>		4 DATE OF DEATH Month <b>11</b> Day <b>20</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/3/1912</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>10</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11 BIRTHPLACE (County & State or foreign country) <b>N. Y.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Patrick Murphy</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Cahalin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes 1941-1963</b>		16. SOCIAL SECURITY NO. <b>060-07-9980</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma, left</b> 10x1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>pulmonary tuberculosis, far advanced</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9/6/1967</b> to <b>11/20/1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/20/1967</b> , and that death occurred at <b>1:10A</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>11/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-22-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or town) (County) (State) <b>Arlington Va.</b>
24. FUNERAL DIRECTOR <b>J. C. COLLINS 3821-14th ST. N.W. WASH. D.C.</b>		25a. REC'D BY REGISTRAR <b>NOV 24 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

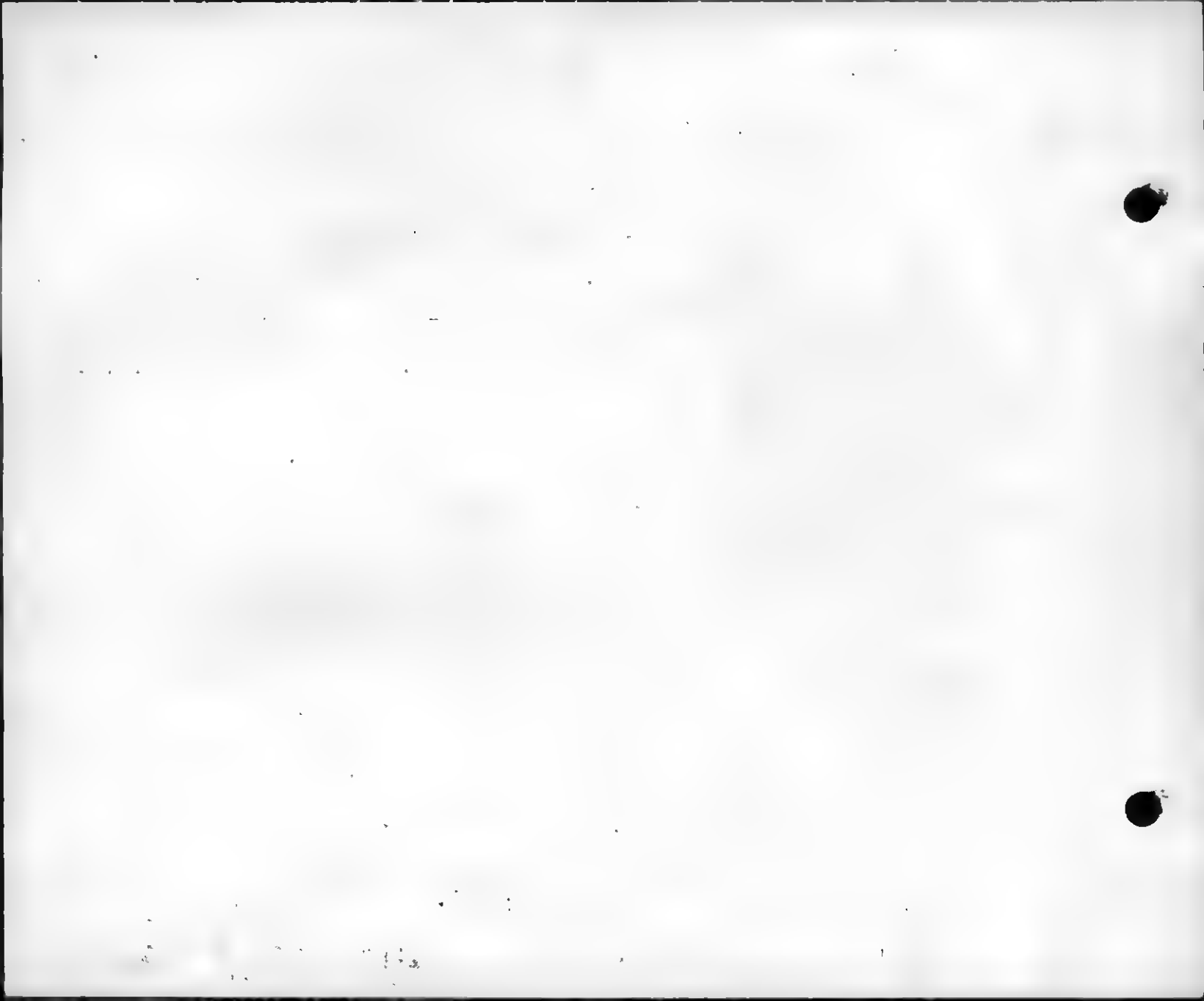
15898

CERTIFICATE OF DEATH

15880

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>	
c. LENGTH OF STAY IN 1b <b>21 days</b>		d. STREET ADDRESS <b>6403-45th Place</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ninnie</b> Middle <b>E.</b> Last <b>Neel</b>		4. DATE OF DEATH Month <b>11</b> Day <b>25</b> Year <b>1967</b>	
5 SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-2-76</b>
9 AGE (In years last birthday) yrs <b>91</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11 BIRTHPLACE (County & State or foreign country) <b>Va.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>JOSEPH CLAYTON BOGLE</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA BOGLE</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO	
17 INFORMANT <b>HARRIETT BEAM, DAU. SAME AS #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4341 CONGESTIVE HEART FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ACUTE PNEUMONITIS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>11-4</b> , 19 <b>67</b> , to <b>11-25</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-25</b> , 19 <b>67</b> , and that death occurred at <b>9:05 PM</b> , from causes on and on the date stated above			
22a. SIGNATURE <b>C. J. Houmann</b>		22b. DATE SIGNED <b>11-26-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. J. HOUMANN</b>		22d. ADDRESS <b>RIVERDALE MD.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11/29/67</b>	23c NAME OF CEMETERY <b>Red Oak Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Ceres Blad Virginia</b>
24. FUNERAL DIRECTOR <b>Gasch's</b>		25a. REC'D BY REGISTRAR <b>DEC 1 1967</b>	
ADDRESS <b>Hyattsville, Maryland</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

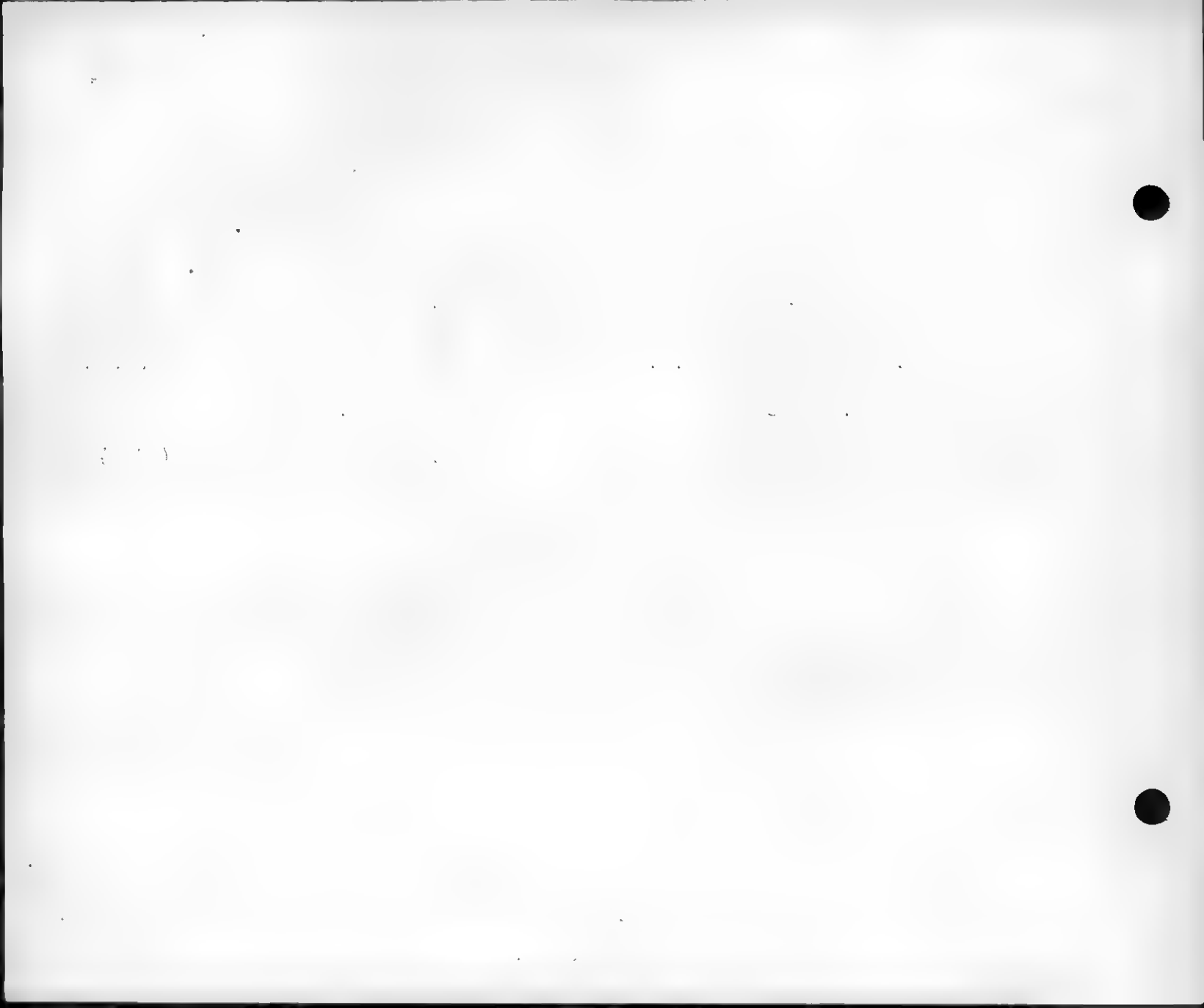
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15891

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Prince George's</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>14 days</b>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		d STREET ADDRESS <b>4903 Edmonston Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>P.</b> Last <b>Nowell</b>		4 DATE OF DEATH Month <b>Nov.</b> Day <b>17</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1/14/08</b>
9. AGE (In years lost birthday) yrs <b>59</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>C.I.A.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel Co, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William G. Nowell</b>		14. MOTHER'S MAIDEN NAME <b>Annie E. Hartge</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>577 10 7666</b>	
17. INFORMANT <b>Alice M. Nowell Same as #2 (wife)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe coronary arteriosclerosis with Left</b> DUE TO <b>ventricular infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Generalized peritonitis</b> DUE TO <b>Chronic pyelonephritis</b> (c) <b>Atelectasis of Right Lower Lobe</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3:40 p.m.</b> , 19 <b>67</b> , to <b>November 17 1967</b> , that (I) (we) last saw the deceased alive on <b>17 Nov</b> 19 <b>67</b> , and that death occurred at <b>10:55 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Robert Deitz</b>		22b. DATE SIGNED <b>11/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert Deitz</b>		22d. ADDRESS <b>Prince George Plaza Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/21/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>		23d. LOCATION (City or town) (County) (State) <b>Laurel P.G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 22 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James Judge</b>			



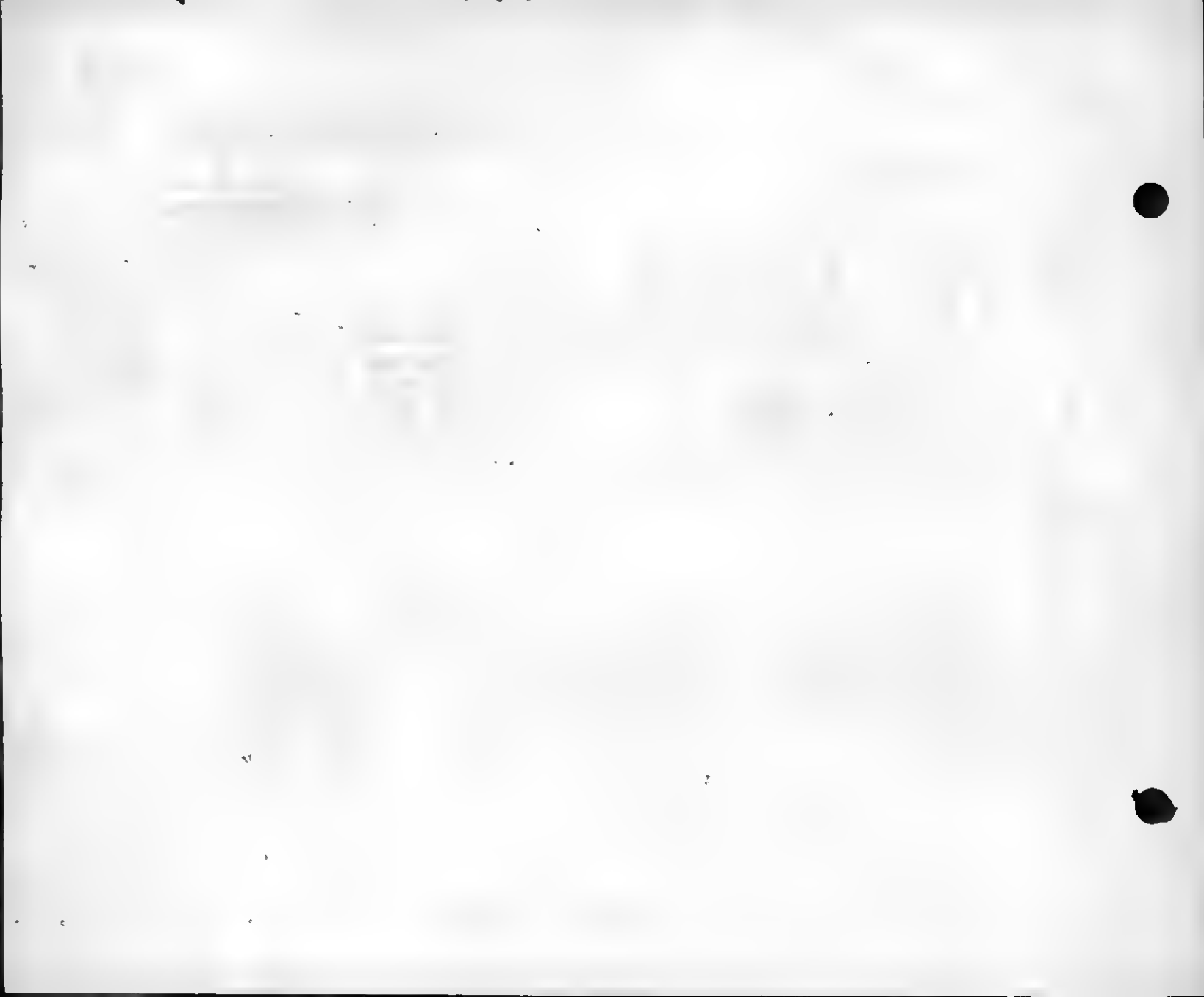
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15882

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>P.G.</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>PRINCE GEORGES</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORESTVILLE</b>		c LENGTH OF STAY IN 1b <b>7-18-67</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Regent N. Home</b>		d STREET ADDRESS <b>7602 Elmhurst Street</b>	
3 NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>MAY</b> Last <b>OWENS</b>		4 DATE OF DEATH Month <b>11</b> Day <b>7</b> Year <b>1967</b>	
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2-25-1895</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	11 BIRTHPLACE (County & State, or foreign country) <b>XXXXXX MARYLAND</b>
13 FATHER'S NAME <b>GEORGE W. BARNES</b>		14 MOTHER'S MAIDEN NAME <b>EVA MILLARD</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO.	17 INFORMANT <b>J. THEODORE OWENS</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Lympho SARCOMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>APR</b> , 1965, to <b>NOV. 7</b> , 1967, that (I) (we) last saw the deceased alive on <b>NOV. 6</b> , 1967, and that death occurred at <b>2:10</b> AM, from causes and on the date stated above.			
22a SIGNATURE <b>W.B. Sheen</b>		22b DATE SIGNED <b>Nov. 7, 1967</b>	
22c PHYSICIAN'S NAME (Type) <b>WALTER B. SHEEN</b>		22d ADDRESS <b>6400 MARLBORO PIKE SE WASH. DC</b>	
23a BURIAL, CREMATION, OR DISPOSAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>11/10/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>	23d LOCATION (City or Town) (County) (State) <b>SUITLAND, PRINCE GEORGES, MD.</b>
24 FUNERAL DIRECTOR <b>Rabbi E. Weisfeld</b>		25a REC'D BY REGISTRAR <b>NOV 10 1967</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (B)  
6M 1/67

Items 20&21 Film 397		MAY 21 1967		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		15893	
2-2-68 AMM 15901				MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY in lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>4712 Oliver Street</b>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Wendy Star Parks</b>				4 DATE OF DEATH Month Day Year <b>11 22 19 67</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>11-9-1967</b>		9 AGE (In years last birthday) yrs. <b>13</b>	IF UNDER 1 YEAR Months Days Hours Min <b>13</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Pro Geo County Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13 FATHER'S NAME <b>Harry W Parks Sr</b>				14 MOTHER'S MAIDEN NAME <b>Betty L Woods</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>none</b>		17 INFORMANT Address <b>Harry W Parks Riverdale, Md.</b>			
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: <b>936.0</b> IMMEDIATE CAUSE (a) <b>Subdural and subarachnoid hemorrhage</b> DUE TO <b>Trauma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of item 28) <b>Hit on face by 16 month old child</b>					
20c TIME OF DEATH Month Day Year Hour am <b>8:00 AM 11-21 19 67</b>		20d PLACE OF INJURY (In home, factory, street, office, etc.) While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (In home, factory, street, office, etc.) <b>Living room-home</b>		20f (City or town) (County) (State) <b>Riverdale Pr. Geo. Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		M.D. <b>Riverdale, Md.</b>		22. DATE SIGNED <b>11-22-67</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Nov 24, 1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>	
24 FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a REC'D BY REGISTRAR DATE <b>NOV 27 1967</b>	
				25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1-26911



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

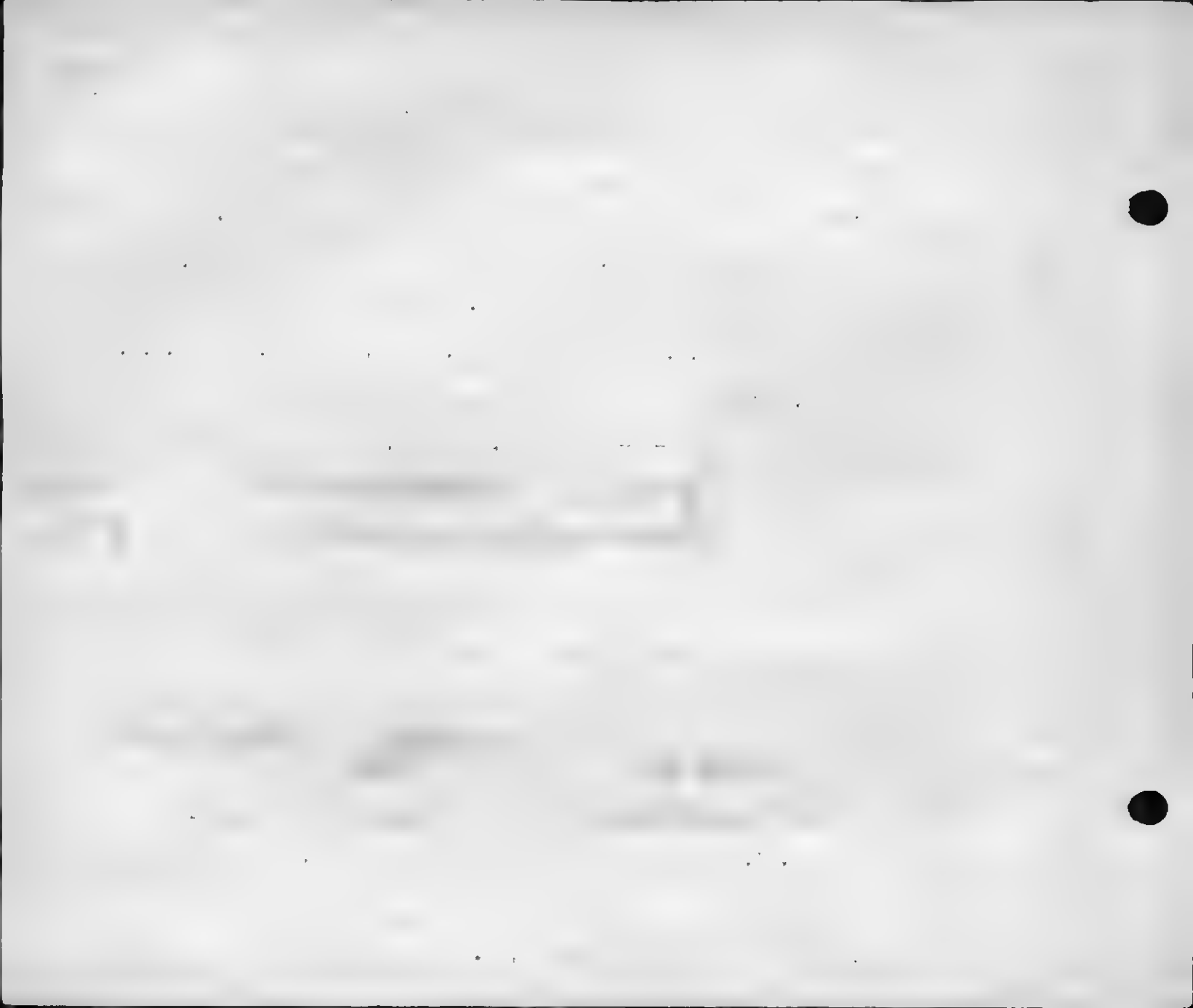
15002

15004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greenbelt Convalescent Center</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Vienna</u> d. STREET ADDRESS <u>10013 Clearfield Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>ELIZABETH D. PARROTT</u> First Middle Last <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Caucasian</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Aug. 28, 1900</u> <b>9. AGE</b> (In years last birthday) <u>67</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.				<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerk</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Government</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Mt. Holly, New Jersey</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Harry G. Duvall</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Rogers</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>578-09-9554D</u> <b>17. INFORMANT</b> <u>Mrs. James M. Miller</u> Address <u>10013 Clearfield Vienna, Virginia</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Decomposition</u> DUE TO (b) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 day</u> <u>4 day</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>11-19-67</u> Hour a.m. p.m. <u>3:00</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <u>Vienna</u> (County) <u>Fairfax</u> (State) <u>VA</u>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11-19-67</u> , to <u>11-25-67</u> , that (I) (we) last saw the deceased alive on <u>11-24-67</u> , and that death occurred at <u>3:00</u> P.M. from the causes end on the date stated above.							
<b>22a. SIGNATURE</b> <u>Wm. C. Weintraub</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Wm. C. Weintraub</u>				<b>22b. DATE SIGNED</b> <b>22d. ADDRESS</b> <u>Greenbelt, Maryland</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/27/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Suitland</u> (State) <u>Maryland</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Money &amp; King</u> ADDRESS <u>Vienna, Va.</u> <b>25a. REC'D BY REGISTRAR</b> <u>NOV 28 1967</u> <b>25b. REGISTRAR'S SIGNATURE</b>					





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VR A15 (4)  
25M 1/67

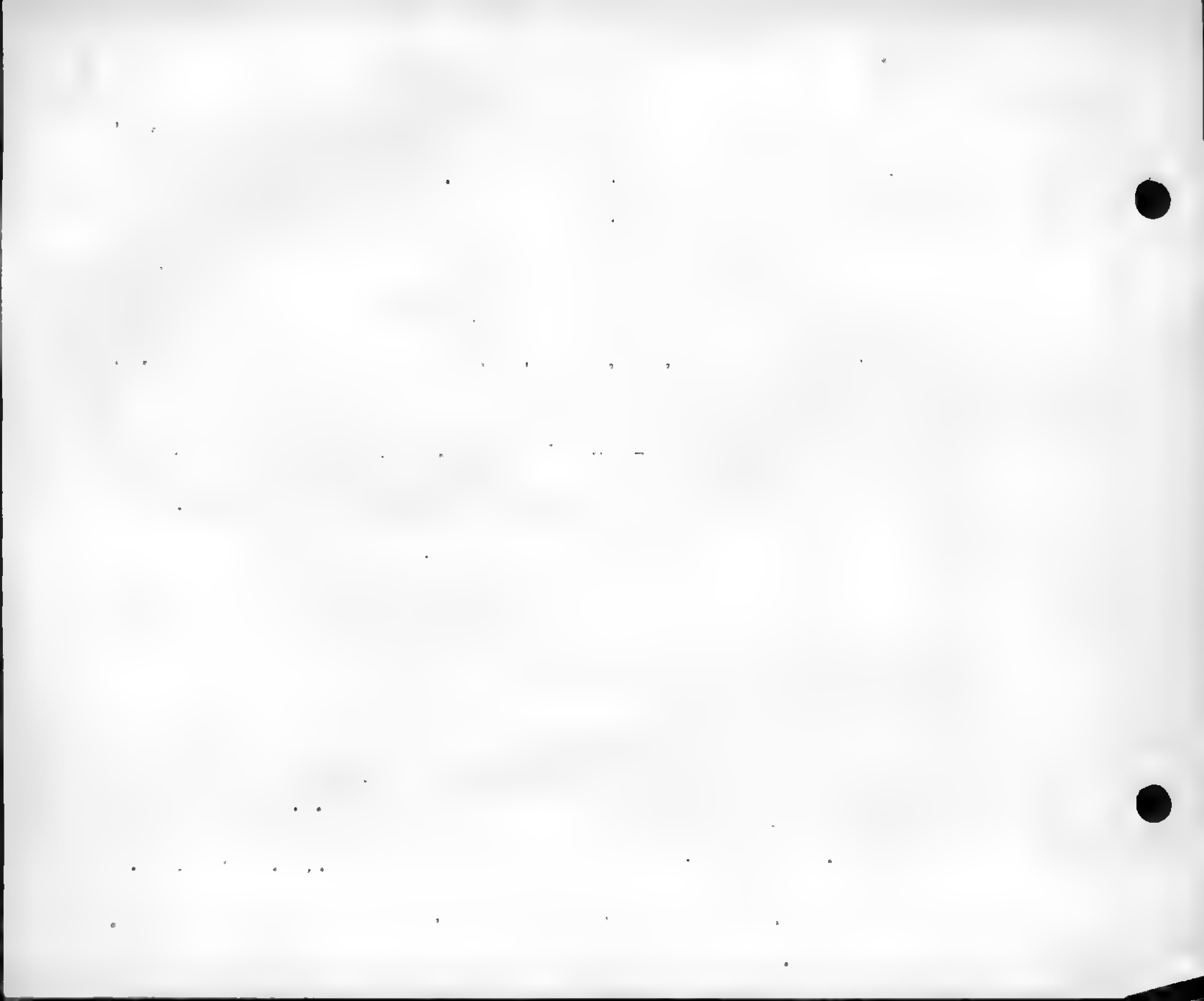
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15903

CERTIFICATE OF DEATH

15885

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>11 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>			d. STREET ADDRESS <b>4303 29th Street</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louis Earl Payne</b>				4. DATE OF DEATH Month Day Year <b>November 21 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/5/1893</b>		9. AGE (In years lost birthday) yrs. <b>74</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C. &amp; P. Tele. Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Payne</b>				14. MOTHER'S MAIDEN NAME <b>Roberta Haynes</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-01-2066A</b>		17. INFORMANT Address <b>Mrs. Hazel A. Payne (above address) (Wife)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma to the liver and brain.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchogenic Carcinoma, right upper lobe</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>19 60</b> to <b>NOV</b> , 1967, that (1) (we) last saw the deceased alive on <b>NOV 20</b> 19 67 and that death occurred at <b>7:30</b> M. from causes and on the date stated above.							
22a. SIGNATURE <b>Benjamin S. Miller</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Benjamin S. Miller</b>				22d. ADDRESS <b>3824 34th St., Mt. Rainier, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/24/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Valley's Funeral Home Inc.</b>				ADDRESS <b>Mt. Rainier Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



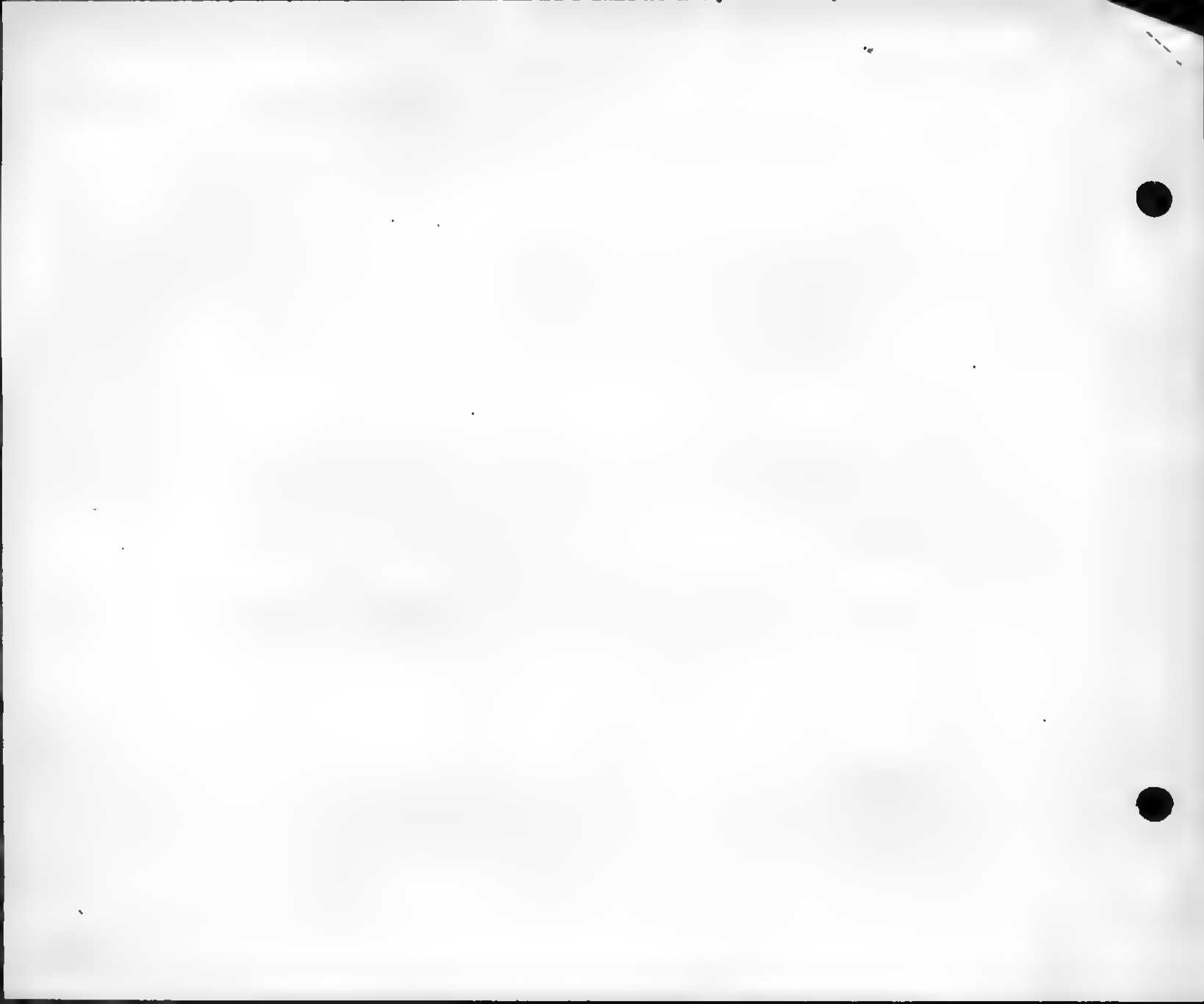
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1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #9 Film #3395 12/5/67 ph  
**CERTIFICATE OF DEATH**

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>12</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE, MD.</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL MANOR</u>		d. STREET ADDRESS <u>SEABROOK, MARYLAND.</u> <u>6701-96TH AVENUE</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>ALICE</u> <u>HELENA</u> <u>PEACHEK</u>		4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-1878</u>
9. AGE (In years and days) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>21</u> Hours <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC, SALES</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ILLINOIS</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ILLINOIS</u>		12. CIT ZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HOMER SWEETZ</u>		14. MOTHER'S MAIDEN NAME <u>ANNA MARIE HOLLINGSHEAD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>490-24-0240</u>	
17. INFORMANT <u>Sister M. Malone</u>		Address <u>4922 LA SALLE RD. Carroll Manor</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO (b) <u>Cerebral Vase Thrombosis</u> DUE TO (c) <u>Sen. Arteriosclerosis (Cerebral)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 months</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>Nov</u> , 19 <u>67</u> , that (I)(we) last saw the deceased alive on <u>Nov 20</u> , 19 <u>67</u> , and that death occurred at <u>6:20 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>James J. Foster</u>		22b. DATE SIGNED <u>11/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES J. FOSTER</u>		22d. ADDRESS <u>1746 K ST N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Nov. 24, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>HIGHLAND LAWN CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>TERRE HAUTE INDIANA</u>	
24. FUNERAL DIRECTOR <u>HANLOW Funeral Home</u>		25a. REC'D BY REGISTRAR <u>NOV 30 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>WASH. DC.</u>		25c. REGISTRAR'S SIGNATURE <u>WASH. DC.</u>	



**IN HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

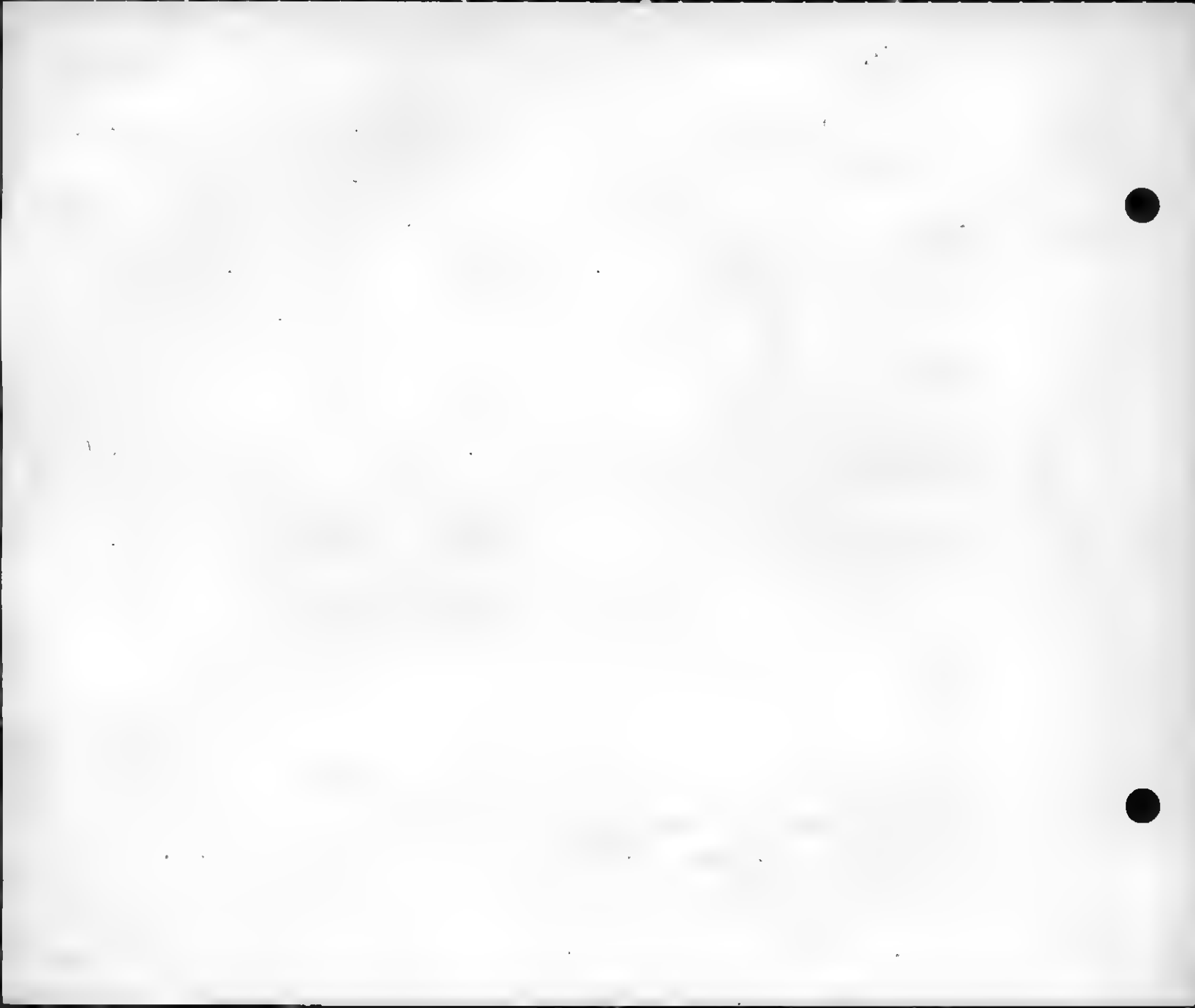
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edmonston</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edmonston</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4802 51st Place</b>				d. STREET ADDRESS <b>4802 51st Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>F.</b> Last <b>Powell</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>12,</b> Year <b>19 67</b>			
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH	
9 AGE (In years last birthday) yrs <b>64</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>		11 BIRTHPLACE (County & State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Edward Powell</b>				14. MOTHER'S MAIDEN NAME <b>Alice Fenimore</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>216 07 6658</b>		17 INFORMANT Address <b>Mrs. Maude L. Powell Same as #2 (wife)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 4. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1</b> , 19 <b>67</b> , to <b>Nov 12</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov 11</b> , 19 <b>67</b> , and that death occurred at <b>7:41</b> AM, from causes and on the date stated above							
22a. SIGNATURE <b>Ermo P. Ingel</b> M.D.				22b. DATE SIGNED <b>Nov 12 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Ermo P. Ingel, M.D.</b>	
22d. ADDRESS <b>Washington D. C.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 15, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 17 1967</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles George</i>			



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Medical examiner Dr John Kehoe notified and approved on Nov 13, 1967.

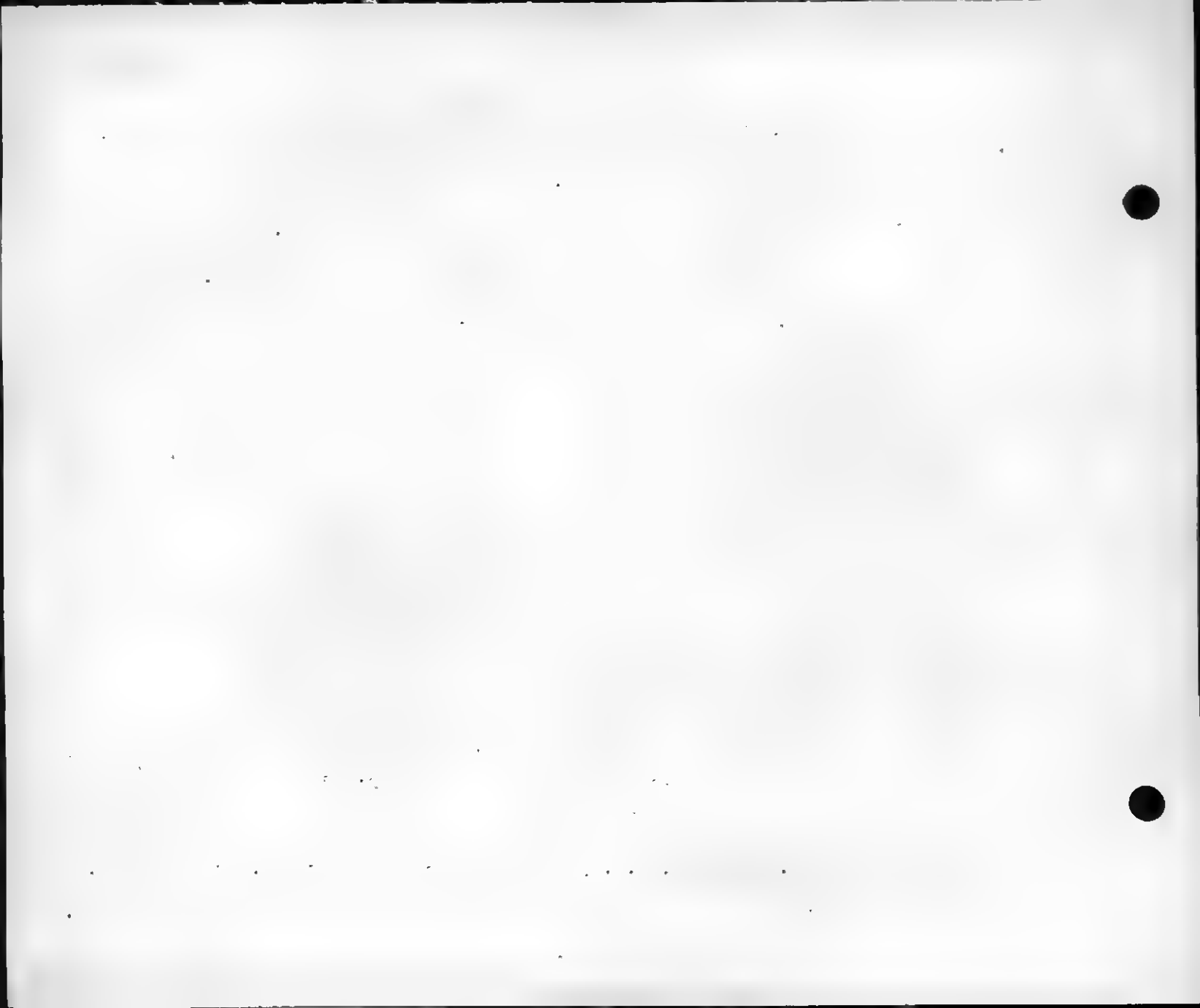
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15906

15898

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>15 hrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>7506 Forest Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Oliver</b> Middle <b>Price</b> Last <b>Price</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>13</b> Year <b>19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-27-32</b>	
9. AGE (In years lost birthday) <b>35</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D C Government</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Claude O Price</b>		14. MOTHER'S MAIDEN NAME <b>Addie M Davis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>577 42 3691</b>		17. INFORMANT <b>Doris J Price</b> Address <b>Kentland, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>5810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Massive upper GI bleeding</b> DUE TO (c) <b>Hepatic cirrhosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) <del>the hospital</del> attended the deceased from <b>11/13</b> , 19 <b>67</b> , to <b>11-13</b> , 19 <b>67</b> , that (1) <del>the</del> last saw the deceased alive on <b>11-13</b> 19 <b>67</b> , and that death occurred <b>09:10P</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Max M. Herzberg, M.D.</b>				22b. DATE SIGNED <b>11-14-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Max M. Herzberg, M.D.</b>	
22d. ADDRESS <b>3308 Dodge Park Rd. Landover, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 17, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John A. Judge</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15907

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

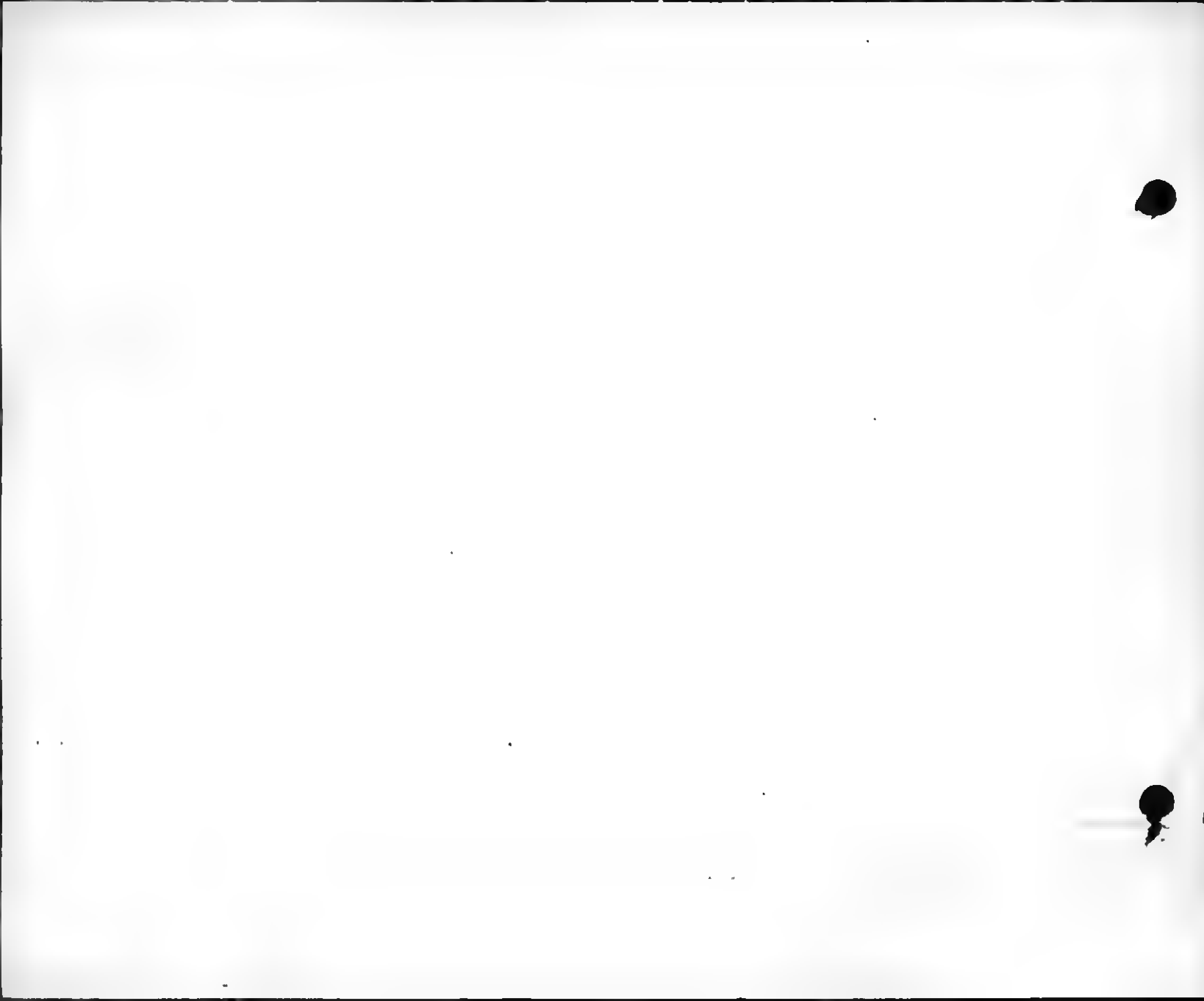
15899

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Shadyside		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Ida Jane Proctor				4. DATE OF DEATH Month Day Year 11 6 1967			
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-20-40		9 AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital worker		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Shadyside Md.		12. CIT ZEN OF WHAT COUNTRY? US 17	
13. FATHER'S NAME Frederic E Proctor				14. MOTHER'S MAIDEN NAME Lucy Estep			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO		17. INFORMANT Lucy E Proctor Shadyside Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary emboli DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Peripheral Venous thrombosis DUE TO (c) Immobilization for treatment of multiple fractures, 17 days INTERVAL BETWEEN ONSET AND DEATH 24 hours							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 18) driver of car involved in collision					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 7:30am p.m. 10-20 1967		20d. INJURY OCCURRED Where at work <input type="checkbox"/> Not where at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Rte. 202 & Town Farm Rd., Upper Marlboro, P.G. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				22. DATE SIGNED 11-6-67			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Nov 8 1967		23c. NAME OF CEMETERY OR CREMATORY Woodside		23d. LOCATION (City or town) (County) (State) Arlington AA Md	
24. FUNERAL DIRECTOR Bernard Hardaway Garrison, Md				25a. REC'D BY REGISTRAR DATE NOV 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

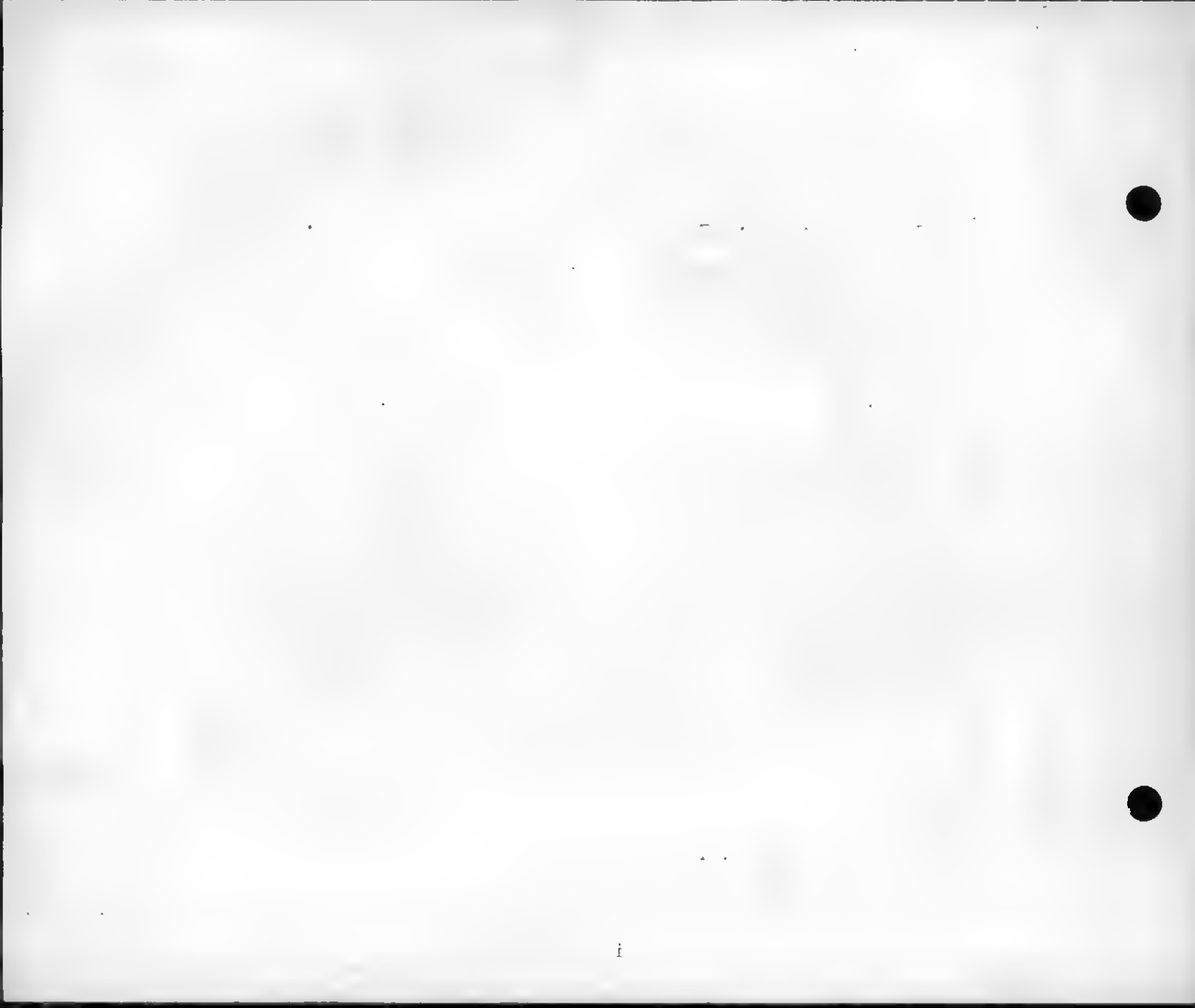
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BLADENSBURG</b> c. LENGTH OF STAY IN 1b <b>BLADENSBURG</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>5018-57th AVE. APT. A-1</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BLADENSBURG</b> d. STREET ADDRESS <b>5018-57th Ave.</b> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>F.</b> Last <b>PULLIN</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 26, 1876</b>
9. AGE (In years last birthday) <b>91</b> yrs		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John E. Sipe</b>		14. MOTHER'S MAIDEN NAME <b>Mary A. Hull</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Pauline Campbell</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Heart Disease</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>15 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>March 3, 1957</b> to <b>Nov. 8, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 7, 1967</b> , and that death occurred at <b>11 P.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Charles C. Hageage</b>		22b. DATE SIGNED <b>Nov. 9, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles C. Hageage</b>		22d. ADDRESS <b>3308 Perry St. Mt. Rainier, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/11/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.G. Md.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 14 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/66

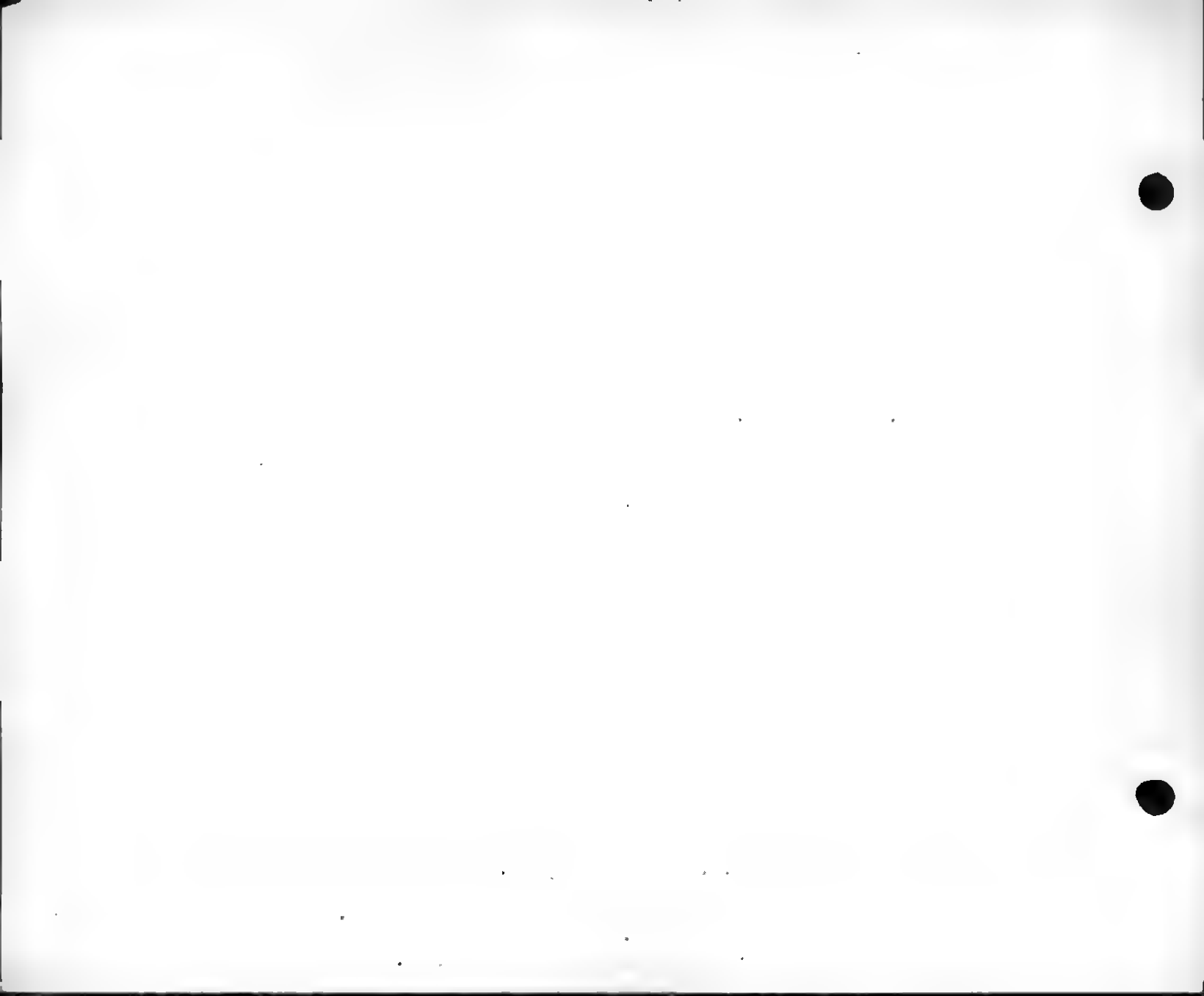
15908

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

15901

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY N 15 <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>			d. STREET ADDRESS <b>5016 Townesend Way</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Robert Wilton Renfroe (JR.)</b>			4. DATE OF DEATH <b>11 7 19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 June 1934</b>	9. AGE (In years last birthday) <b>33</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Active Duty Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Robert W. Renfroe (SR.) living</b>		
14. MOTHER'S MAIDEN NAME <b>Madeline Neuben living</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		
16. SOCIAL SECURITY NO <b>524-36-2012</b>			17. INFORMANT <b>Ruby Gale (Bowers) Renfroe</b>		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of gastric contents</b> X DUE TO <b>And metastatic carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>From carcinoma of stomach</b> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED <b>11-9-67</b>		23. ACTUAL SIGNATURE <b>John Kehoe, M.D.</b> Riverdale, Md.			
24. EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		25. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
26. ADDRESS (Street, city, town or county) _____		27. ADDRESS (Street, city, town or county) _____			
28a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		28b. DATE THEREOF <b>11/13/67</b>		28c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem. Arlington, Virginia</b>	
28d. LOCATION (City or Town) _____ (County) _____ (State) _____		29. REC'D BY REG. STRAR <b>NOV 13 1967</b>			
30. REGISTRAR'S SIGNATURE <b>P. Charles Judge</b>		31. REGISTRAR'S SIGNATURE _____			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15010

1982

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 113 (Main Street)</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>Box 113 (Main Street)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles Edward Ridgely</b>		4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1889</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret'd Carpenter</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Edward Ridgely</b>		14. MOTHER'S MAIDEN NAME <b>Marian Marie Sweeney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.I. 220-09-6257</b>	
17. INFORMANT <b>Mrs. Marie M. Ridgely-Same as Item #2.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. (c) DUE TO	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1946</b> to <b>3 hr.</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2 hr.</b> 19 <b>67</b> , and that death occurred at <b>4:45 A.M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Dr. Robert B. Sasscer, M.D.</b>		22b. DATE SIGNED <b>11/3/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert B. Sasscer, M.D.</b>		22d. ADDRESS <b>Upper Marlboro, Maryland 20870</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/6/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cometary</b>		23d. LOCATION (City, town or county) (State) <b>Upper Marlboro, Md.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Brothers</b>		25. REC'D BY REGISTRAR <b>NOV 14 1967</b>	
26. ADDRESS <b>Upper Marlboro, Md.</b>		27. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

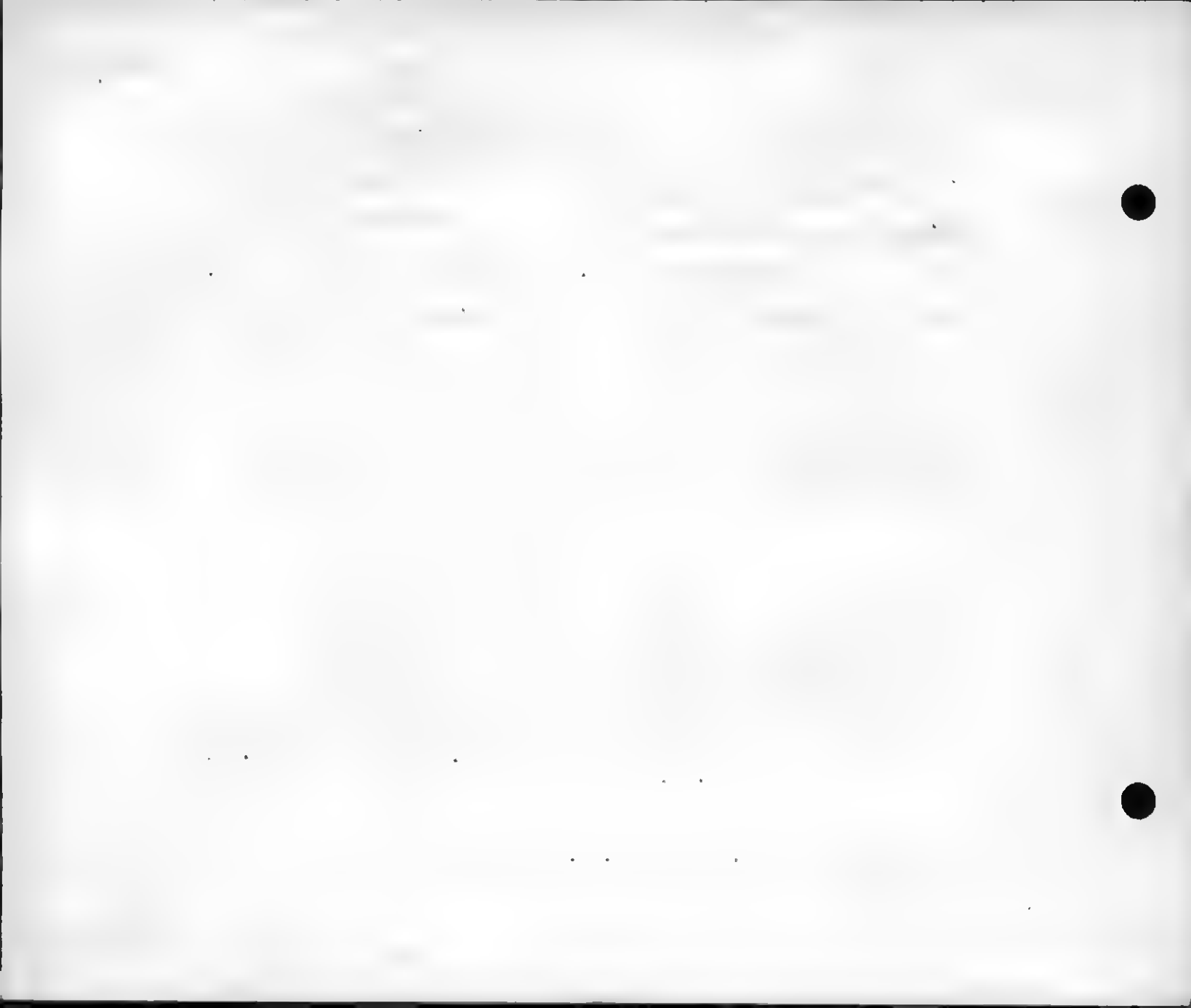
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15011

15903

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY in 1b <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b> d. STREET ADDRESS <b>2120 Upsher Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Edward E. Riles</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>4</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/15/94</b>	9. AGE (In years last birthday) <b>73</b> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gravedigger</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Riles</b>				14. MOTHER'S MAIDEN NAME <b>Jennie?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WWI</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>William Chase 4110 Balt. Ave Bladensburg</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung + Pneumonia</b> DUE TO (b) <b>Metastases to Liver</b> DUE TO (c) <b>lost</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>Oct. 31, 1967</b> , to <b>Nov. 4, 1967</b> , that <del>the</del> (we) last saw the deceased alive on <b>Nov. 4, 1967</b> , and that death occurred at <b>11 P.M.</b> from causes on and the date stated above.							
22a. SIGNATURE <b>Edwin J. Jensen</b>			M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/7/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M. D.</b>			22d. ADDRESS <b>Prince Georges General Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-9-1967</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cotonsville Md.</b>	
24. FUNERAL DIRECTOR <b>N.S. WASHINGTON &amp; SONS INC.</b> <b>4925 DEANE AVE. N.E. WASH., D.C.</b>				25a. REC'D BY REGISTRAR <b>OAT NOV 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

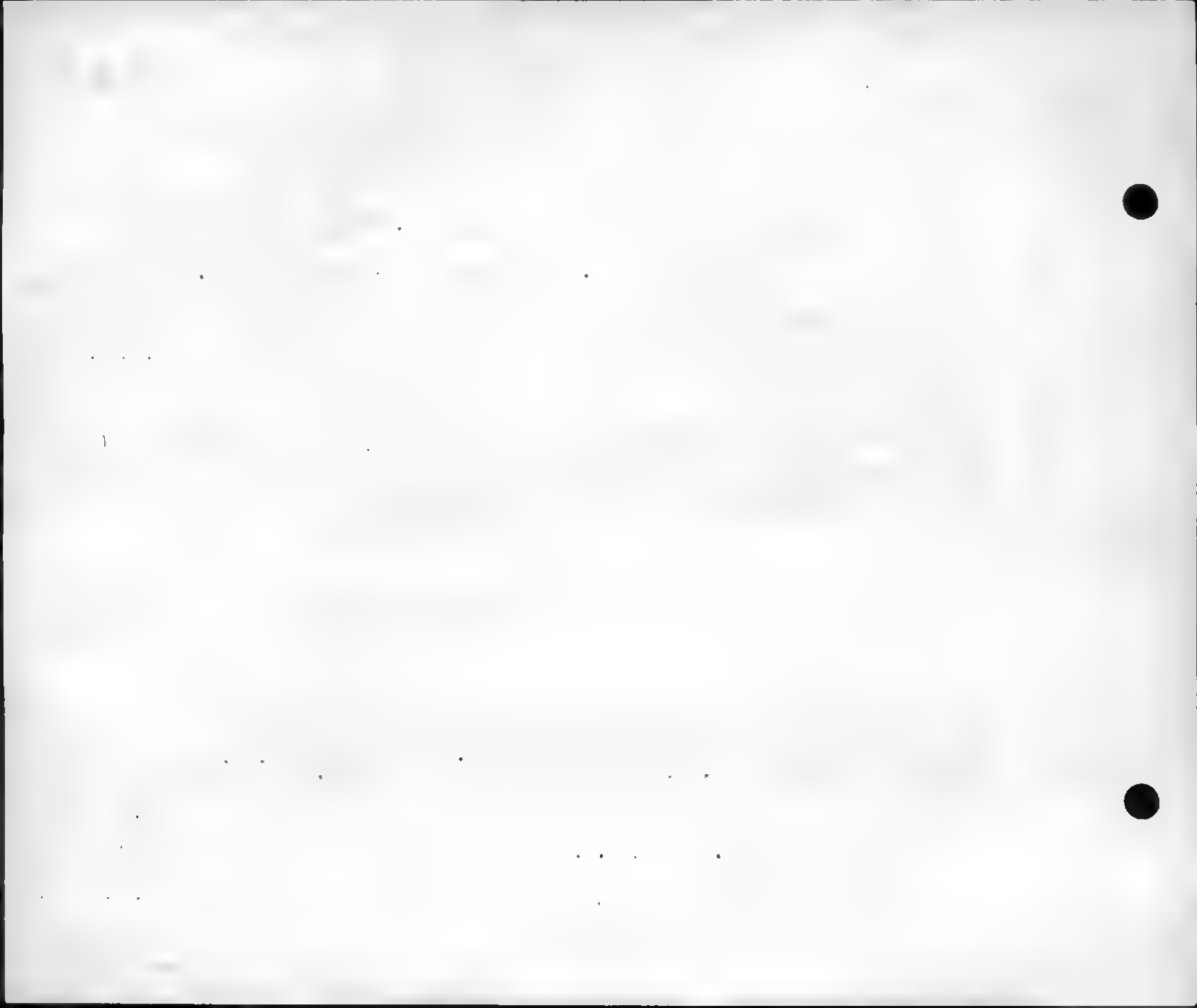
15912

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15904

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>9 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b> d. STREET ADDRESS <b>7008 F. Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Amos Rogers Sr.</b>				4. DATE OF DEATH Month Day Year <b>Nov. 8, 1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/26/18</b>	
9. AGE (In years last birthday) <b>49 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction</b>				10b. KIND OF BUSINESS OR <b>Building</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Layton Rogers</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Lilly</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>225 24 4896</b>		17. INFORMANT <b>Marguerite K. Rogers Same as #2 (wife)</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (u) (this hospital) attended the deceased from <b>Oct. 30, 1967</b> , to <b>Nov. 8, 1967</b> , that (u) (we) last saw the deceased alive on <b>Nov. 8, 1967</b> , and that death occurred at <b>1 P.M.</b> from causes and on the date stated above							
22a. SIGNATURE <b>Arnold G. Brody</b>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>9 Nov 67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/11/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 14 1967</b>		25b. REG. STRAR'S SIGNATURE <b>Charles J. J...</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

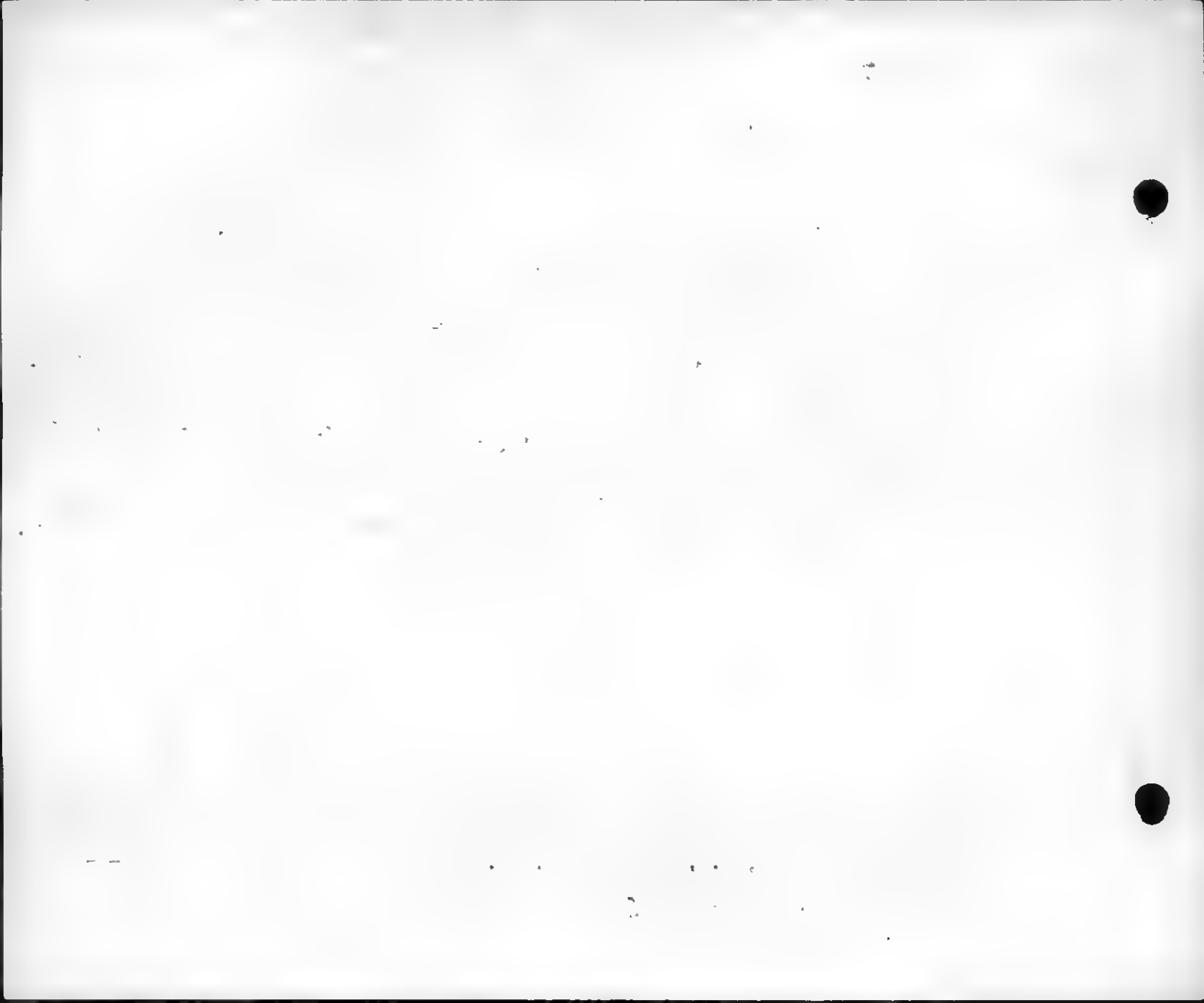
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11913

11571

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN JB <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Hungerford Ruddy</u>		4 DATE OF DEATH Month Day Year <u>11 30 19 67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-1899</u>
9 AGE (in years last birthday) <u>68</u> yrs		10. F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life even if retired) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVERNMENT</u>	
11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Christopher Ruddy</u>		14. MOTHER'S MAIDEN NAME <u>THEKLA BOWMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO <u>225 07 7544</u>	
17. INFORMANT <u>MRS. VIRGINIA RUDDY, SAME AS #2.</u>		Address	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 3 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u>		22. DATE SIGNED <u>12-1-67</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>		RIVERDALE, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-4-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEM</u>		23d. LOCATION (City or town) (County) (State) <u>WHEATON, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO. RIVERDALE, MD</u>		25a. REC'D BY REGISTRAR <u>DEC 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution or Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY in 1b <b>21 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		d. STREET ADDRESS <b>3815 Oglethorpe Street</b>	
3 NAME OF DECEASED (Type or print) <b>Leon E.M. Ryder</b>		4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1/24/00</b>
9 AGE (In years lost birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Education, Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Mass.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ryder, Everett</b>		14. MOTHER'S MAIDEN NAME <b>Olhson, Ida</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO. <b>019-09-1618</b>	
17 INFORMANT <b>Allen D. Ryder, Son,</b>		Address <b>706 Gilbert St. Takoma Park, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA with Multiple Lung Abscesses</b> DUE TO (b) <b>ASSOCIATED with ANEMIA</b> DUE TO (c) <b>AND SQUAMOUS CARCINOMA of R+LUNG</b>		INTERVAL BETWEEN ONSET AND DEATH <b>55 DAYS</b> <b>6-12 mo</b> <b>? 18 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>JAUNDICE</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-17</b> , 19 <b>67</b> , to <b>11-7</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-7/67</b> , 19 <b>67</b> , and that death occurred at <b>4:15 pm</b> from causes and on the date stated above.			
22a. SIGNATURE <b>C.J. Houmann</b> M.D.		22b. DATE SIGNED <b>11/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. C.J. Houmann MD</b>		22d. ADDRESS <b>4400 Queensbury Rd. Riverdale</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/10/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.G. Md.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. RECORDED BY REGISTRAR <b>NOV 14 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

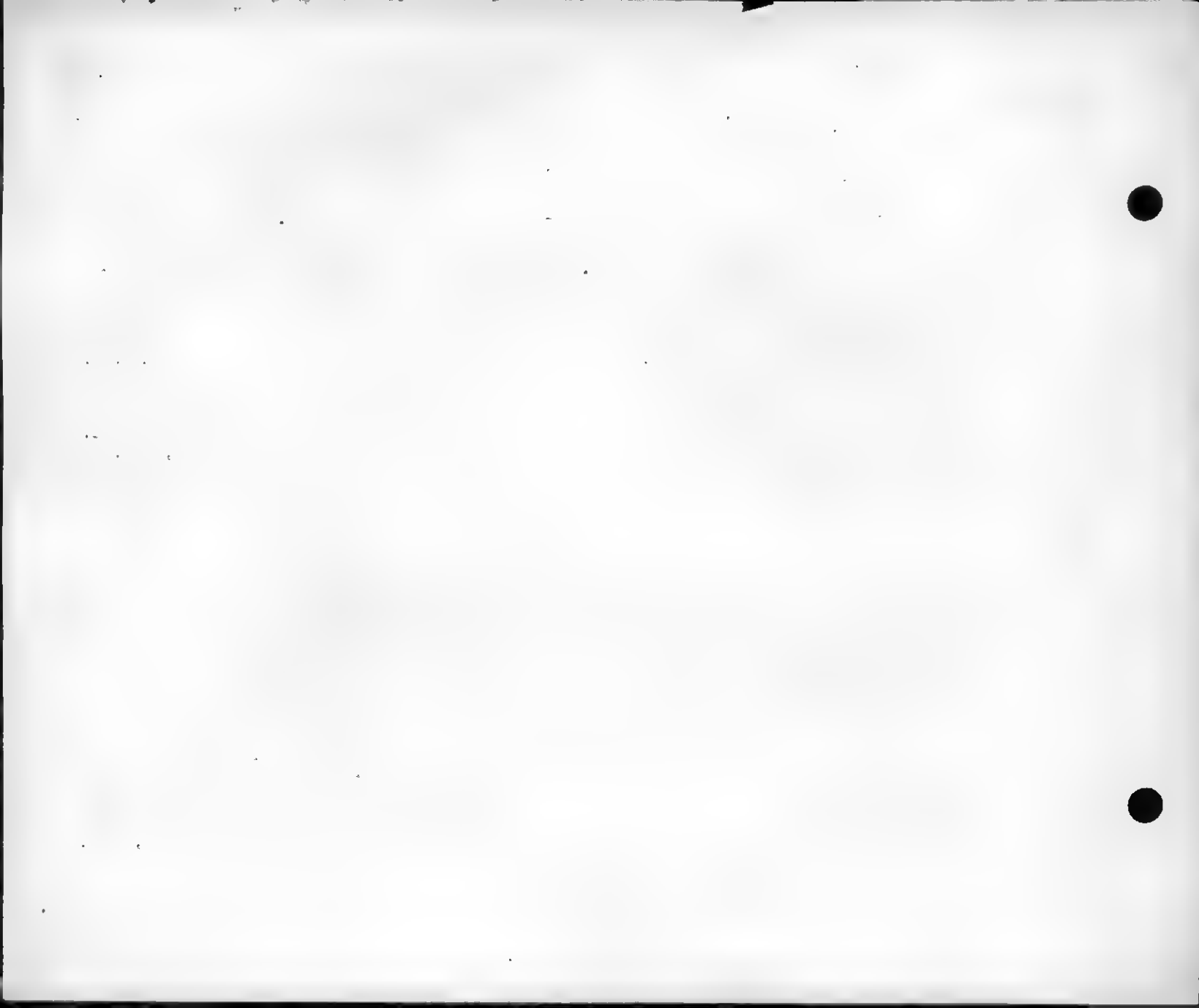
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15915

CERTIFICATE OF DEATH

15906

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN TB <b>12 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Carlyle</b> Last <b>Seward Jr.</b>		4. DATE OF DEATH Month <b>November</b> Day <b>18</b> , Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11/22/02</b>
9. AGE (In years last birthday) <b>64</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penn. Railroad</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Carlyle Seward Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Almina Malliat</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>909 California Ave. Pittsburgh, Pa.</b>	
17. INFORMANT <b>Albert B. Seward</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> DUE TO <b>metastatic Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of tongue</b> DUE TO (c) <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1957</b> to <b>Nov. 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 18, 1967</b> and that death occurred at <b>02:10 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>William C. Weintraub, M.D.</b>		22b. DATE SIGNED <b>11/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>William C. Weintraub, M.D.</b>		22d. ADDRESS <b>Greenbelt, Md. Greenbelt Professional Bldg</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/21/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Louden Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Baltimore Md.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 22 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

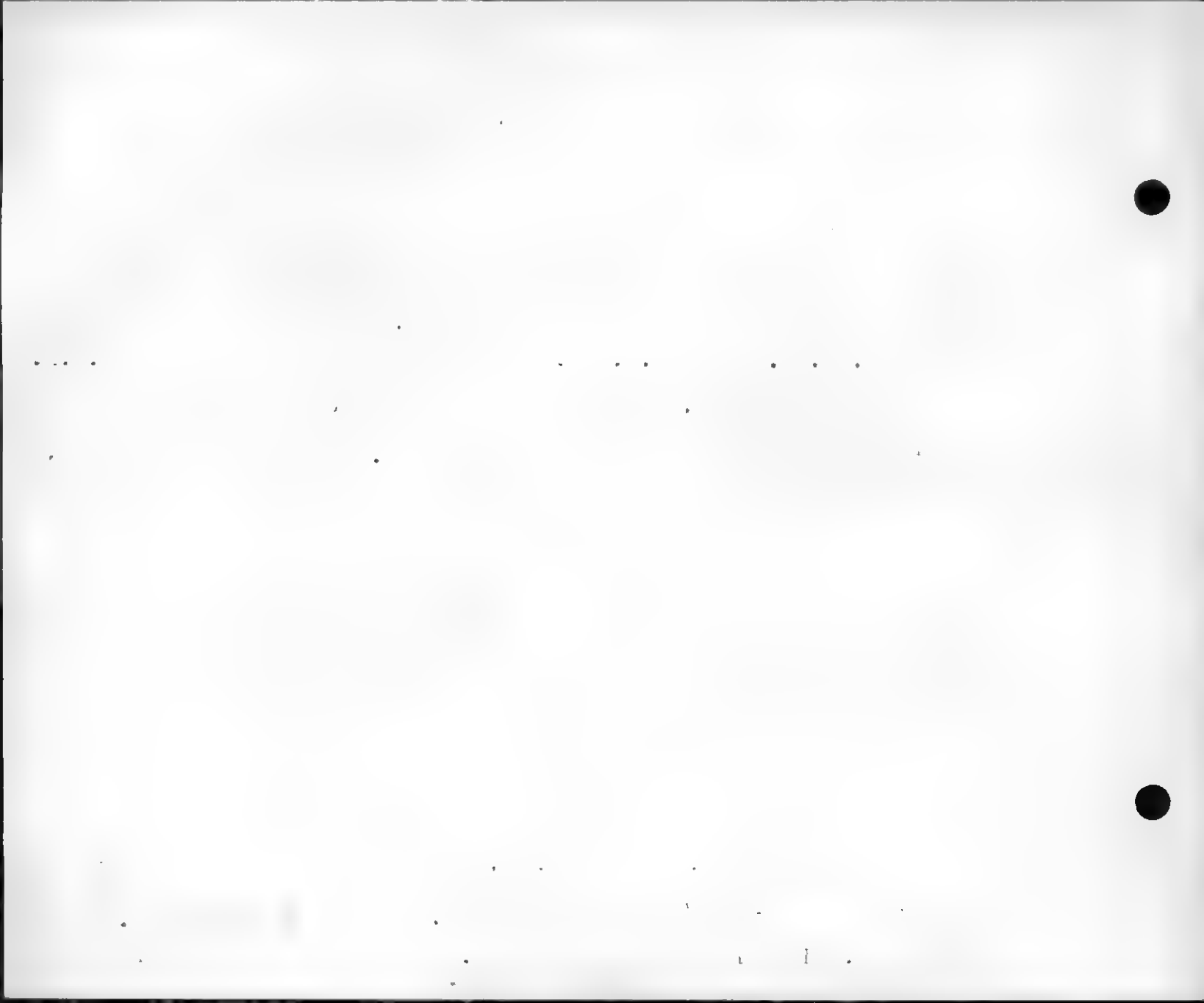
15916

15907

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1005 may be retained for your files  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Alfred Simmons</b>				4. DATE OF DEATH Month Day Year <b>11 27 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 Sept. 1923</b>		9. AGE (In years last birthday) <b>44</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>G. S. A.</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>		11. BIRTHPLACE (State or foreign country) <b>Oklahoma</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clarence C. Simmons</b>				14. MOTHER'S MAIDEN NAME <b>Ruby Merritt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW2</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Juanita D. Simmons 4514 Rena Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>7200</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		M.D. <b>Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>11-27-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-30-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat.</b>		23d. LOCATION (City or town) (County) (State) <b>Arlington Va.</b>	
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm #308 Suitland Rd. Suitland Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



# FOR STATE HEALTH DEPT.

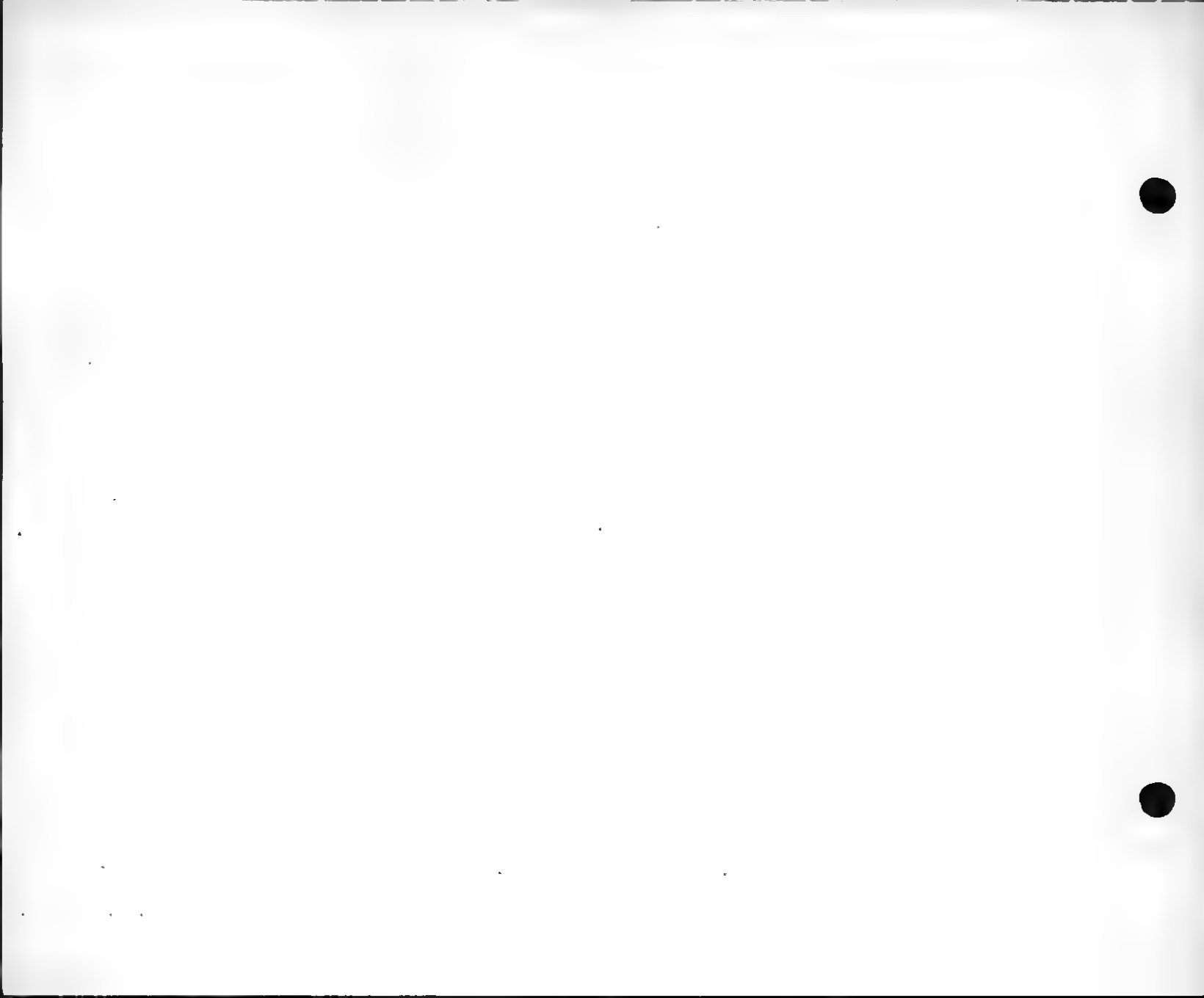
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>7534 Newberry Lane</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Polly Gertrude Slattery</b>		4 DATE OF DEATH Month <b>11</b> Day <b>8</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11-27-1892</b>
9 AGE (In years last birthday) yrs. <b>74</b>		10 IF UNDER 1 YEAR Months <b>74</b> Days <b>19</b> Hours <b>67</b> Min	
10a USUAL OCCUPATION (Give kind of work done in most of work of life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Fred L. Denson</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Jackson</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Charline B. Gates</b>		7534 Newberry Lane Lanham, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Hypertensive cardio vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>over 2 yrs.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b> M.D.		22. DATE SIGNED <b>11-9-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a BURIAL CREMATION (Specify) <b>Burial</b>	23b DATE THEREOF <b>11/11/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.G. Md.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)  
6M 1/67

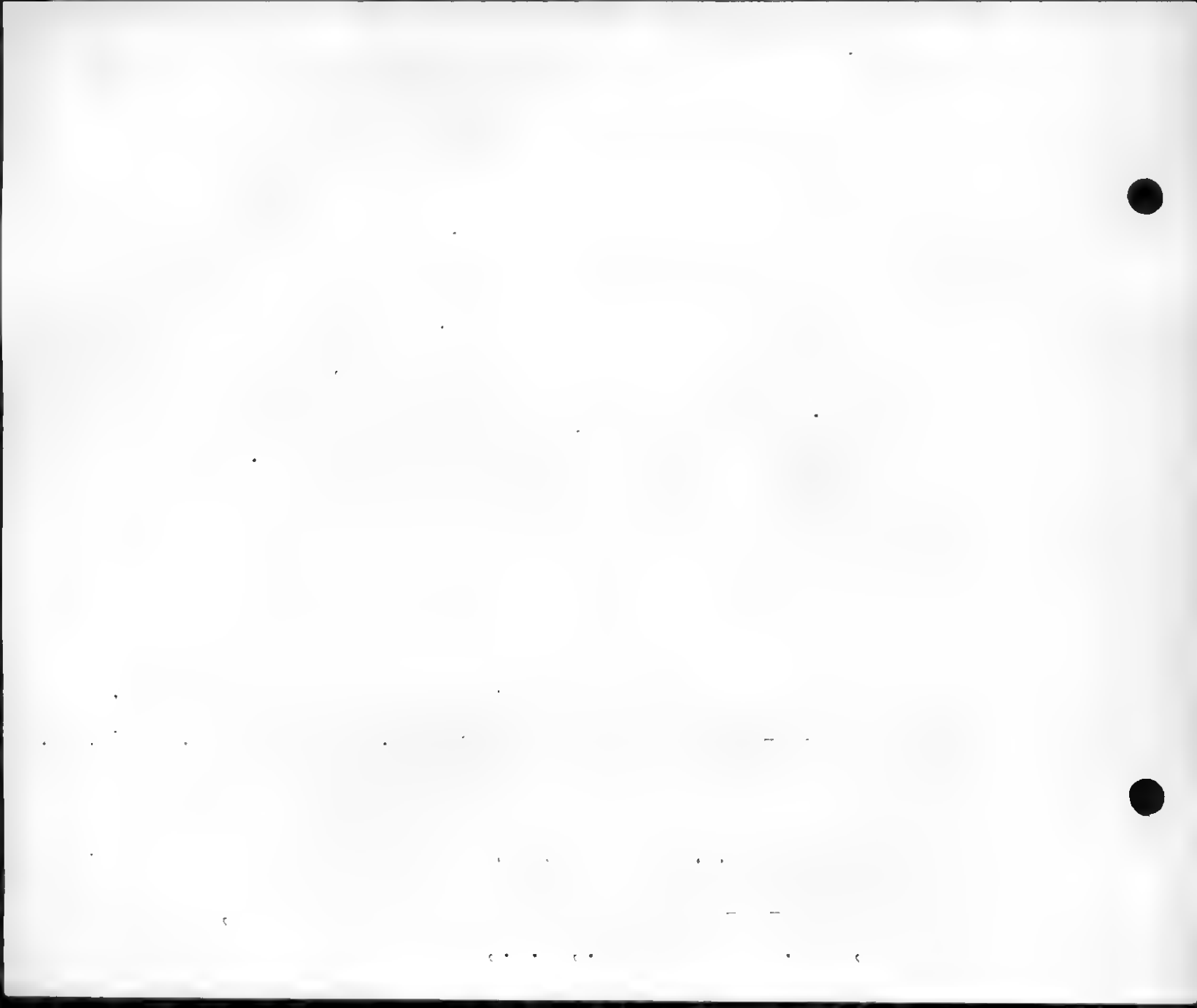
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15918

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15989

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>AN</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c LENGTH OF STAY IN 1b <b>DOA</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e STREET ADDRESS <b>Rtl. Box 40, Bayard Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Oscar Fremont Smith</b>		4 DATE OF DEATH Month Day Year <b>11 16 19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 Jan. 1947</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Glenarden, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William W. Smith</b>		14 MOTHER'S MAIDEN NAME <b>Jeanetta Brooks</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>244-48-1192</b>	
17 INFORMANT <b>Mother</b>		Address <b>Same as 2d.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Laceration of brain</b> DUE TO <b>Trauma - auto accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Occupant thrown from car after collision with tree.</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>2:00am 11-16- 19 67</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Race Track Rd. &amp; Old Chapel Rd.</b>	20f (City or town) (County) (State) <b>Bowie, Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		22. DATE SIGNED <b>11-17-67</b>	
23a BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11-20-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Adams Chapel Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Lothian, Maryland</b>
24 FUNERAL DIRECTOR <b>Rollins, Inc. 4339 Hunt Pl., N.E., DC</b>		25a REC'D BY REGISTRAR <b>NOV 21 1967</b>	25b REGISTRAR'S SIGNATURE <i>James Judge</i>





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

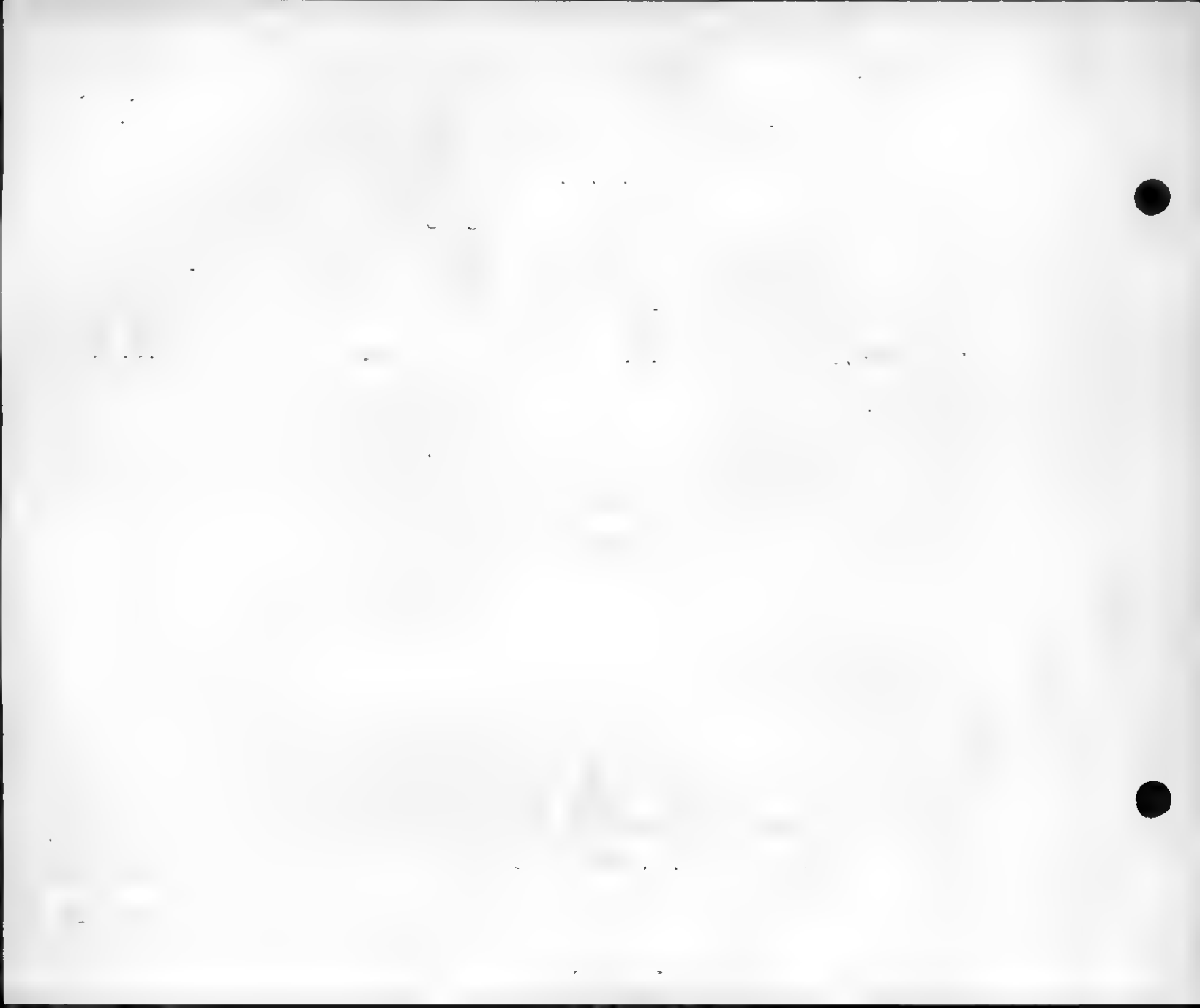
VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15910

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D. O. A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Vincent</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>9,</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 Jan 1916</b>
9. AGE (In years and birth day) <b>51</b> yrs		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>11</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Internal Revenue Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry J. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane McCarten</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>no</b>	
17. INFORMANT <b>Robert K. Smith Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Liver failure</b> DUE TO <b>Cirrhosis of the Liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>11/9/67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M. D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/13/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Truman</b>	23d. LOCATION (City or Town) (County) (State) <b>Kendalltown Wisconsin</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 13 1967</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15920

15911

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PR. GEO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRANDYWINE</b>		c. LENGTH OF STAY IN TB <b>12 YRS.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRANDYWINE</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 424 - Rt. 1</b>	
d. STREET ADDRESS <b>Box 424 - Rt. 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM A.</b> Middle <b>SMYTHERS</b> Last		4. DATE OF DEATH Month <b>NOV</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 1, 1900</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>17</b> Hours <b>17</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMPLOYED</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CARROLL CO. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES SMYTHERS</b>		14. MOTHER'S MAIDEN NAME <b>LELIA CAUDLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>228-09-2816-A</b>	
17. INFORMANT <b>MRS. BETTY SMYTHERS</b>		Address <b>Rt 1 Box 424 BRANDYWINE, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO (b) <b>GENERALIZED CARCINOMATOSIS</b> DUE TO (c) <b>ADENOCARCINOMA OF STOMACH</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVA. BETWEEN ONSET AND DEATH <b>5 MIN.</b> <b>6 MOS.</b> <b>14 MOS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NONE</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>NONE</b> Min. <b>19</b>		20d. INJURY OCCURRED While <b>NONE</b> of work <b>NONE</b> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, etc.) <b>NONE</b>		20f. (City or town) (County) (State) <b>NONE</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE</b> , 19 <b>66</b> to <b>PRESENT</b> , that (I) last saw the deceased alive on <b>NOV 15</b> 19 <b>67</b> , and that death occurred at <b>1430</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Arthur Shaver Jr.</b>		22b. DATE SIGNED <b>11/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR. MD.</b>		22d. ADDRESS <b>8808 BRANCH AVE CLINTON MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-19-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FULL Gospel Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>CEDARVILLE, P.G., MD.</b>	
24. FUNERAL DIRECTOR <b>HUNT FUNERAL HOME, WILDORE, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Death Certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

10912

<b>1 PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SO MARYLAND Hosp - Clinton, Md</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON, MD</u> d. STREET ADDRESS <u>9810 Glenview DR</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3 NAME OF DECEASED</b> (Type or print) First <u>VANGIE</u> Middle <u>B.</u> Last <u>STANTON</u>			<b>4. DATE OF DEATH</b> Month <u>NOV</u> Day <u>15</u> Year <u>1967</u>				
<b>5 SEX</b> <u>7</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <del>WIDOWED</del> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8 DATE OF BIRTH</b> <u>2-11-06</u>	<b>9 AGE</b> (n years last birthday) <u>61</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS</b> Hours <u>  </u> Min <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>ANOCOSTIA, SL DC</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>JOHN L JONES</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>EMMA BRATLER</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO</b>		<b>17. INFORMANT</b> Address <u>JACK STANTON (HUSBAND) SAME</u>			
<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO (b) <u>Acute Pulmonary Embolus</u> DUE TO (c) <u>Acute Thrombophlebitis of leg.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 MIN</u> <u>10 MIN</u> <u>36 HRS</u>	
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Arteriosclerotic CV disease with congestive failure, compensated</u>						<b>19 WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <u>None</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <u>None</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>None</u>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office, etc.) <u>None</u>	<b>20f. (City or town)</b> <u>None</u>	<b>(County)</b> <u>None</u>	<b>(State)</b> <u>None</u>		
<b>21. I certify that (I) (this hospital) attended the deceased from <u>10/29</u>, 19<u>67</u>, to <u>Present</u>, that (I) (we) last saw the deceased alive on <u>Nov 10</u> 19<u>67</u>, and that death occurred at <u>11/15/67</u> from causes on and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Arthur Shaver Jr.</u> M.D.			<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>11/15/67</u>		
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>ARTHUR SHAVER JR. MD</u>			<b>22d. ADDRESS</b> <u>8808 BRANCH AVE. CLINTON, MD</u>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11-18-1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>			
<b>23d. LOCATION (City or town)</b> <u>Suitland, Maryland</u>		<b>(County)</b> <u>  </u>		<b>(State)</b> <u>  </u>			
<b>24. FUNERAL DIRECTOR</b> <u>Brimmons Bros</u> ADDRESS <u>1661-Good Hope Rd SE Wash DC</u>			<b>25a. REC'D BY REGISTRAR</b> <u>NOV 17 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		

Signed with permission of medical examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15922

15913

1. PLACE OF DEATH a. COUNTY <b>Pro Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt, Md.</b> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8150 Lake Crest Drive</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro Geo</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt, Md.</b> d. STREET ADDRESS <b>8150 Lake Crest Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>M.</b> Last <b>STEVENS</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>15</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1904</b>
9. AGE (In years lost birthday) <b>63</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>	
13. FATHER'S NAME <b>Walter Kinsey</b>		14. MOTHER'S MAIDEN NAME <b>Emily Kellett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>James Stevens</b>		Address <b>Crofton, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cordial Arrest</b> <b>4901</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Coronary Artery Disease with left ventricular aneurysm</b> (c) <b>Previous myocardial infarctions</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <b>August</b> , 1964, to <b>Nov 10</b> , 1967, that (I) (we) last saw the deceased alive on <b>Nov 10</b> , 1967, and that death occurred at <b>10:20 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>HAROLD I. PASSES</b>		22b. DATE SIGNED <b>Nov 15 1967</b>	22c. PHYSICIAN'S NAME (Type) <b>HAROLD I. PASSES</b>
22d. ADDRESS <b>1919 Conn Ave NW Wash DC 20009</b>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>buried</b>	23b. DATE THEREOF <b>11/18/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON</b>	23d. (County) (State) <b>Drexel Hill Pa</b>
24. FUNERAL DIRECTOR <b>Francis Sarchi Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 20 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15923

15914

1. PLACE OF DEATH a. COUNTY <u>Prince Georges'</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton, Md.</u>			c. LENGTH OF STAY IN 1b <u>10 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens Health Care Center</u>						d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>CHARLES EDWARD STEVENSON</u>						4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 2, 1895</u>		9. AGE (In years last birthday) <u>72</u> yrs	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM WORKER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>ANNE ARUNDEL CO, Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>William Francis Stevenson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wade</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac cular collapse</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cancer arising from CA of prostate</u> DUE TO (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-28</u> , 19 <u>66</u> , to <u>11-4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11-4</u> , 19 <u>67</u> , and that death occurred at <u>12:40</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <u>Alfred R. Lapin M.D.</u>					22b. DATE SIGNED <u>11-4-67</u>		22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>
22d. ADDRESS <u>CLINTON, MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11-8-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Family</u>		23d. LOCATION (City or town) (County) (State) <u>Woodmont Md</u>	
24. FUNERAL DIRECTOR <u>Rollins 4339-Hunt BL NE</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

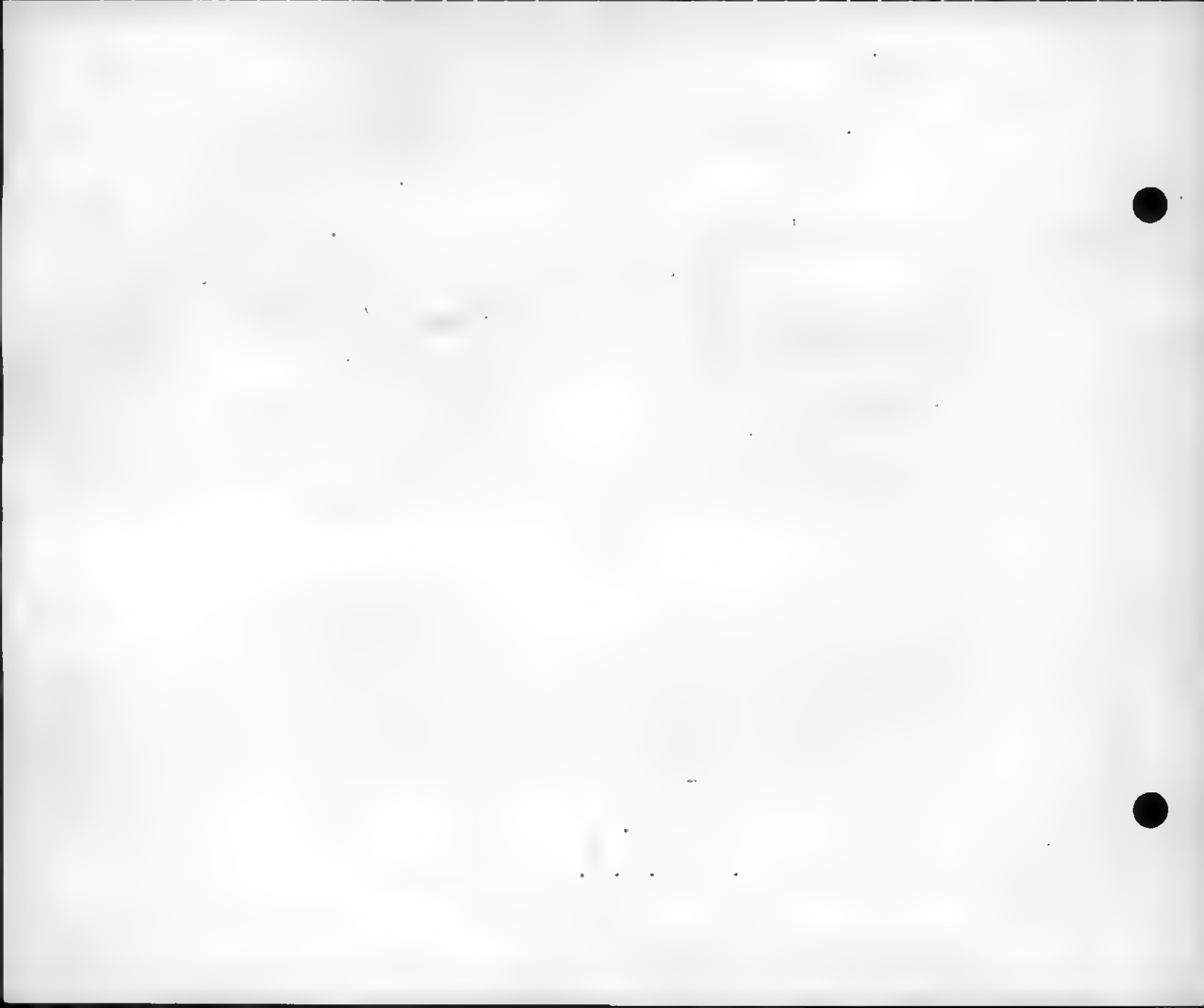
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>prince George's General Hospital</b>		d. STREET ADDRESS <b>6410 K St.</b>	
3 NAME OF DECEASED (Type or print) <b>William Stewart</b>		4. DATE OF DEATH <b>Nov. 11 19 67</b>	
5. SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1885</b> AGE (In years last birthday) <b>82 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17 INFORMANT <b>Neomi Hoskins</b> Address <b>Highland 1108 70th Ave Park</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-5</b> , 19 <b>67</b> , to <b>11-11</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-11</b> , 19 <b>67</b> and that death occurred at <b>10:59 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Arnold G. Brody</b> M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>11 Nov 67</b>
22c. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M.D.</b>		22d ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/17/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ridgely Church</b>	23d. LOCATION (City or Town) (County) (State) <b>Ridgely, Maryland</b>
24. FUNERAL DIRECTOR <b>John T. Stewart</b> Address <b>Stewart Funeral Home 4001 Benning Rd.,</b>		25a. REC'D BY REGISTRAR <b>NOV 16 1967</b> Date E.	25b. REGISTRAR'S SIGNATURE



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

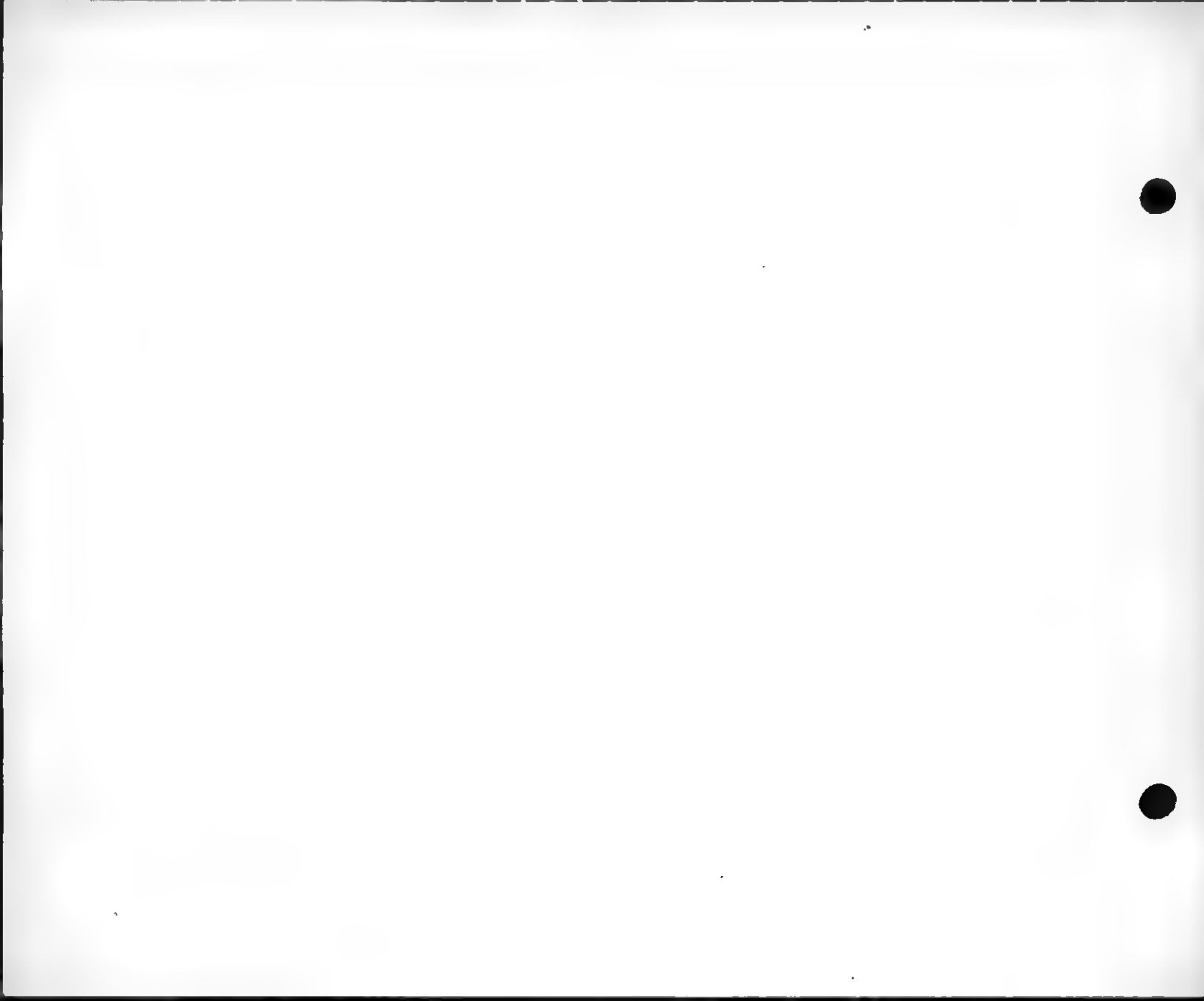
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15925

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15916

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. STREET ADDRESS <b>1107 69th Place</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Henry Stewart</b>		4. DATE OF DEATH Month Day Year <b>11 5 19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-28-07</b>
9. AGE (In years last birthday) yrs <b>59</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>William H. Stewart, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Cook</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Dora M. Stewart</b>		Address <b>1107 69th Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>over 10 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe M.D., Riverdale, Maryland</b>		22. DATE SIGNED <b>11-6-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11/11/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR <b>Stewart Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>11/11/67</b>	25b. REGISTRAR'S SIGNATURE <b>William A. Judge</b>



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

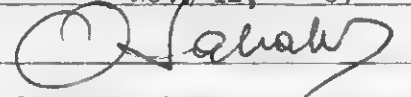
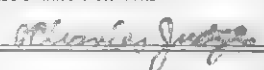
**CERTIFICATE OF DEATH**

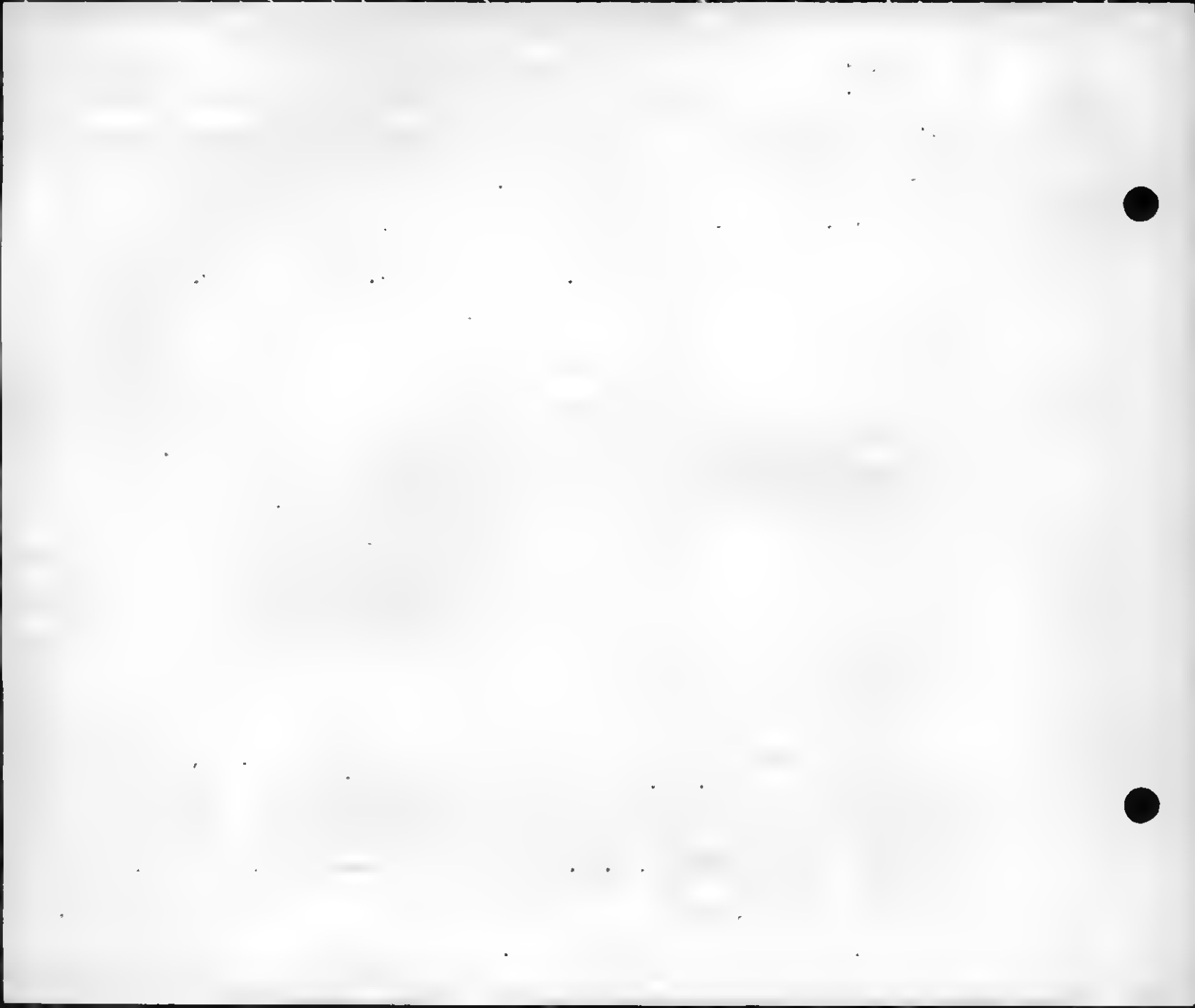
15926

15917

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN It <b>4 days/11 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>2814 64th Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Georges W. Sullivan, Sr.</b>				4. DATE OF DEATH Month Day Year <b>Nov 12 19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-9-26</b>	
9. AGE (In years lost birthday) <b>41</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (County & State, or foreign country) <b>Washington D C</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington D C</b>	
13. FATHER'S NAME <b>George Washington Sullivan</b>				14. MOTHER'S MAIDEN NAME <b>Eva Busey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes W W II</b>				16. SOCIAL SECURITY NO. <b>W W II</b>		17. INFORMANT <b>Grace Sullivan</b> Address <b>Cheverly, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia Infection</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Arteriosclerosis Coronary Heart.</b> DUE TO <b>Coronary Insufficiency</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 years</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(the physician)</del> attended the deceased from <b>Jan. 1964</b> to <b>Nov. 12, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Nov. 12, 1967</b> , and that death occurred at <b>2:50 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) <b>Ohannes Sahakyan, M. D.</b>				22b. DATE SIGNED <b>Nov. 13, 1967</b>		22d. ADDRESS <b>6001 Landover Road, Cheverly, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 16, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor rro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>Nov 17 1967</b>		25b. REGISTRAR'S SIGNATURE 	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15927

15918

1 PLACE OF DEATH a. COUNTY Prince Georges Hospital MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admssion) a. STATE Md b. COUNTY St Mary's ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Elsie Middle Louise Last Swain		4 DATE OF DEATH Month Nov Day 28 Year 19 67	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug 20, 1913
9 AGE (In years lost birthday) 54 yrs		10 UNDER 1 YEAR Months Days Hours Min	11 UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Levi Hill		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 217 28 8428	
17 INFORMANT Lake Swain		Address Mechanicsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5705 Coronary thrombosis DUE TO (b) Shock DUE TO (c) Intestinal obstruction			INTERVAL BETWEEN ONSET AND DEATH 2 days 18 hrs 5 days
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystectomy 11/20/67			19 WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/14, 1967, to 11/28, 1967, that (I) (we) last saw the deceased alive on 11/28, 1967, and that death occurred at 2:50 P.M. from causes on and on the date stated above			
22a SIGNATURE John H. Bayly		22b DATE SIGNED Nov 29, 1967	
22c PHYSICIAN'S NAME (Type) JOHN H. BAYLY		22d ADDRESS 1835 EYE N.W., WASH. D.C. 20006	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Dec 1, 1967	23c NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	23d LOCATION (City or Town) (County) (State) Washington D C
24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a REC'D BY REGISTRAR DATE DEC 5 1967	25b REGISTRAR'S SIGNATURE Charles Judge



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

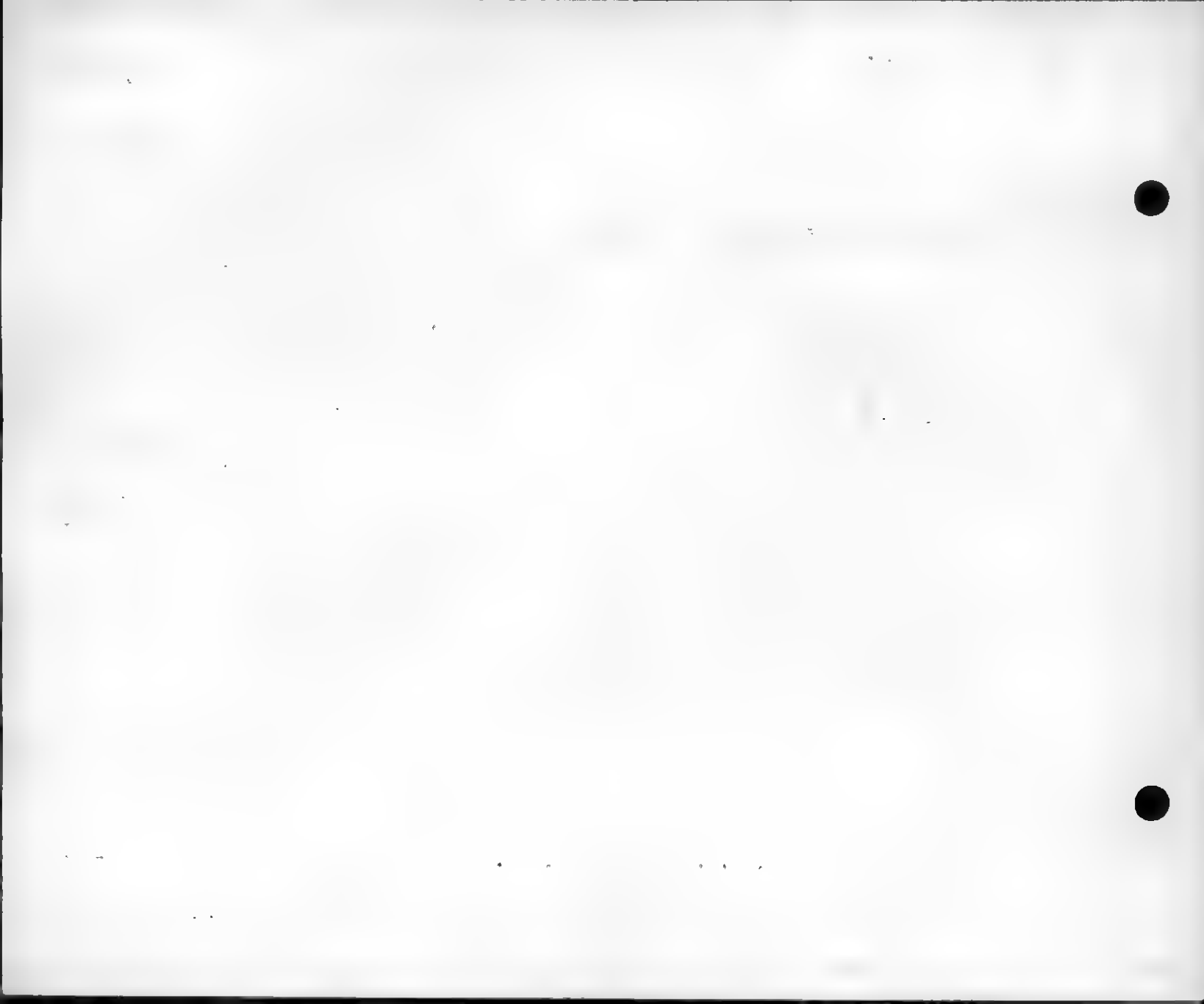
**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15928

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

15919

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst. l. on Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>4 CRESTWOODHANE,</b>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>R</b> Last <b>Szper</b>		4. DATE OF DEATH Month <b>11</b> Day <b>11</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug 24, 1923</b>
9. AGE (In years lost birthday) <b>44</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>SHADYSIDE, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK SZPER</b>		14. MOTHER'S MAIDEN NAME <b>ALBERTA BURAK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>JOSEPH C. SZPER</b>		Address <b>13123 LARCHDALE RD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4200</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>11-13-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>Nov 15, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HOLY CROSS CEMETERY</b>		23d. LOCATION (City or town) (County) (State) <b>ARLINGTON, N.J.</b>	
24. FUNERAL DIRECTOR <b>J. Charles Judge</b>		25a. REC'D BY REGISTRAR <b>NOV 15 1967</b>	
ADDRESS <b>5550 WASHINGTON BLVD</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

Item 21 Film 397 2-16-68		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		Item 21 Film 398 3-7-68 ams	15920
<b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>					
1 PLACE OF DEATH a COUNTY <b>Prince George's</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Prince George's</b>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c LENGTH OF STAY IN 1b <b>DOA</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>			d STREET ADDRESS <b>9116 8th. Street</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>Rozalia</b> Middle <b>Szunyogh</b> Last <b>Szunyogh</b>			4 DATE OF DEATH Month <b>11</b> Day <b>29</b> Year <b>19 67</b>		
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7-21-1939</b>		9 AGE (In years last birthday) yrs <b>28</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11 BIRTHPLACE (State or foreign country) <b>Hungary</b>	
13 FATHER'S NAME <b>Jonas Hodvagner</b>			14 MOTHER'S MAIDEN NAME <b>Unknown</b>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOC. SEC. NO.		17 INFORMANT <b>Karoly Szunyogh Same as #2 (husband)</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carbon monoxide intoxication</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Inhaled carbon monoxide while sitting in car</b>			
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>11-29-19 67</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	
		20f (City or town) <b>same as #2</b>		(County) _____ (State) _____	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		22 DATE SIGNED <b>11-30-67</b>	
23a BURIAL (CREMATION, REMOVAL) (Specify) <b>Burial</b>		23b DATE THEREOF <b>12/4/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	
		23d LOCATION (City or Town) <b>Colmar Manor P.G. Md.</b>		(County) _____ (State) _____	
24 FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		ADDRESS		25a REC'D BY REGISTRAR <b>DEC 5 1967</b>	
				25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

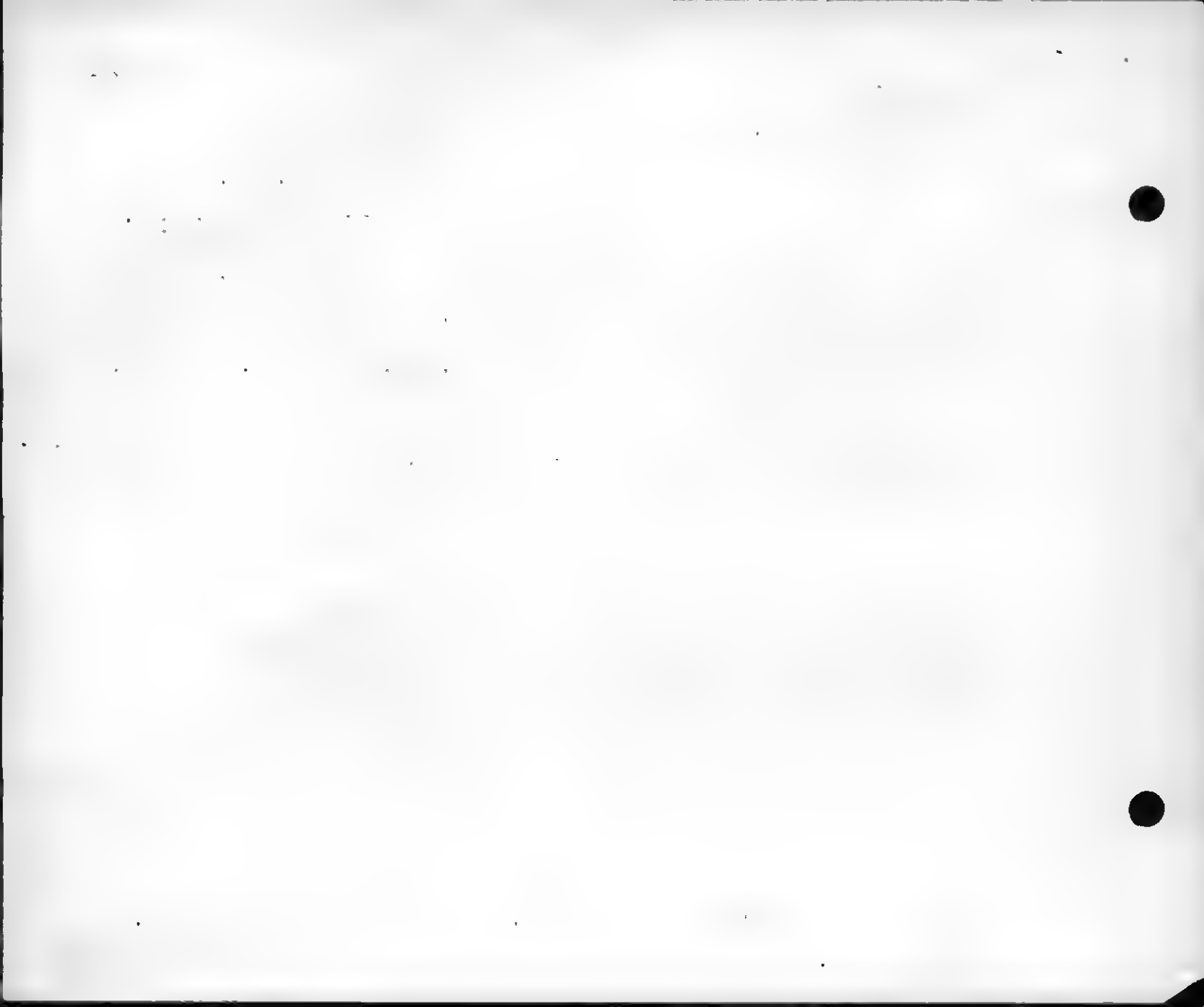
**CERTIFICATE OF DEATH**

**15921**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton, Maryland</u>			c. LENGTH OF STAY in it <u>85 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs, Pr. Geo. County, Md. 16</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland General Hospital</u>				d. STREET ADDRESS <u>6904 Allentown Rd. S. E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Thomas</u> Middle <u>Moody</u> Last <u>Taylor</u>				<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>27</u> Year <u>1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 9, 1882</u>		
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pr. Geo. County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Joseph Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Young</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>217-36-8376-A</u>		17. INFORMANT Address <u>Thomas V. Taylor, 6931 Sheffield Dr. Camp Springs, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> DUE TO (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO (c) <u>ADVANCED AGE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OLD TBC, ACTIVITY NOT PROVED, POSS. RENAL TBC</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1967</u> , to <u>Nov 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 27, 1967</u> , and that death occurred at <u>4 A.</u> M., from causes and on the date stated above.								
22a. SIGNATURE <u>Robert W. Merkle M.D.</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11/27/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>ROBERT W. MERKLE M.D.</u>				22d. ADDRESS <u>SO. MD. GEN. HOSP. CLINTON, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 27, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Christ Epis. Church Cemetery-- Clinton, Md.</u>		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <u>Simons Bros</u>				ADDRESS <u>1001 Good Hope Rd SE Wash DC</u>		25a. REC'D BY REGISTRAR <u>NOV 29 1967</u>		
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

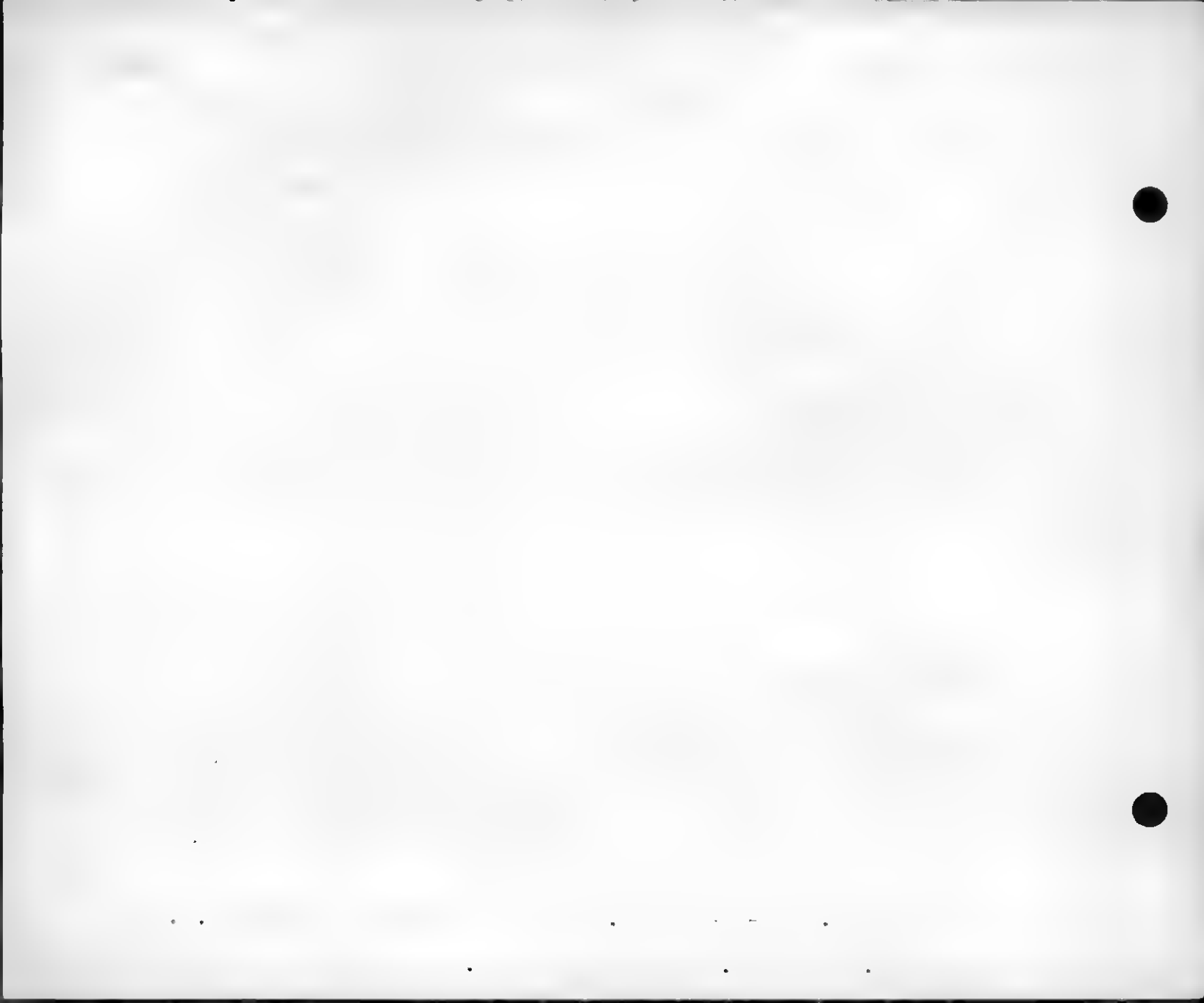
CERTIFICATE OF DEATH

15922

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MALCOLM GROW USAF HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALAN TEITLER		4. DATE OF DEATH Month Day Year NOV 20 19 67	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 JAN 1941
9. AGE (In years lost birthday) 26 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN		10b. KIND OF BUSINESS OR INDUSTRY USAF	
11. BIRTHPLACE (County & State, or foreign country) BROOKLYN, NEW YORK		12. COUNTRY OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACK TEITLER		14. MOTHER'S MAIDEN NAME ROSLYN FINK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. AUG67-Present 059-34-5727	
17. INFORMANT WIFE		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>241x</u> ASPHYXIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) STATUS ASTHMATICUS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 19 Nov., 19 67, to 20 Nov 67, that (X) (we) lost the deceased alive on 20 Nov 19 67 and that death occurred at 0145 M, from causes and on the date stated above.			
22a. SIGNATURE John F. Lindeman		22b. DATE SIGNED 20 Nov 67	
22c. PHYSICIAN'S NAME (Type) JOHN F. LINDEMAN, CAPT, USAF, MC		22d. ADDRESS Malcolm Grow USAF Hosp Andrews AFB Wash DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Removal Bur.	11-21-67	Mt. Lebanon Cemetery	Queens, N.Y.
24. FUNERAL DIRECTOR Falls Church Funeral Home 1102 W. Broad St. Falls Church, Va.		25a. REC'D BY REGISTRAR DATE NOV 24 1967	25b. REGISTRAR'S SIGNATURE J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15931

15923

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Powder Mill</u>		c. LENGTH OF STAY IN 1b <u>16</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pineview Gardens Health Care Center</u>		d. STREET ADDRESS <u>Fletcher Town Rd.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>MARY FRANCIS THOMAS</u>		4. DATE OF DEATH Month Day Year <u>NOV 9 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>March 2, 1875</u>
9 AGE (In years last birthday) <u>92</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min <u>11.3.12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. C. I. ZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Lawns</u>		14. MOTHER'S MAIDEN NAME <u>UNK.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>21356-8009T</u>	
17. INFORMANT <u>Medicare</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>114X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of the</u> DUE TO (c) <u>Carcinoma of the</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 m.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-7</u> , 19 <u>67</u> to <u>11-9</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>11-9</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred K. Lapin</u>		22b. DATE SIGNED <u>11-9-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED K. LAPIN</u>		22d. ADDRESS <u>CLINTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-13-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Anne Arundel Co Md</u>
24. FUNERAL DIRECTOR <u>A-S. Washington &amp; Son</u>		25a. REC'D BY REGISTRAR <u>11-13-67</u>	
25b. REGISTRAR'S SIGNATURE <u>11-13-67</u>		DATE NOV 14 1967	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15932

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB BASE		c. LENGTH OF STAY IN 1b 18 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MALCOLM GROW USAF HOSPITAL		d. STREET ADDRESS 4714 CEDELL PLACE	
3 NAME OF DECEASED (Type or print) First Middle Last NELLIE RYAN THOMPSON		4. DATE OF DEATH Month Day Year NOV 14 19 67	
5 SEX FEMALE	6 COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Jul 1892
9. AGE (In years lost birthday) 75 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NA	
11 BIRTHPLACE (County & State, or foreign country) OURAY, COLO.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MICHAEL RYAN		14. MOTHER'S MAIDEN NAME MARY HANNON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) (If yes give war or dates of service) NO NA		16. SOCIAL SECURITY NO. NA	
17. INFORMANT HARRY J. THOMPSON (SON) SAME AS #2		Address	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1750 OVARIAN CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour & m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 26 Oct, 1967, to 14 Nov, 1967, that (X) (we) last saw the deceased alive on 14 Nov, 1967, and that death occurred at 0015 M, from causes and on the date stated above.			
22a. SIGNATURE Robert E. Harris		22b. DATE SIGNED 14 Nov 1967	
22c. PHYSICIAN'S NAME (Type) ROBERT E. HARRIS, CAPT, USAF, MC		22d. ADDRESS Malcolm Grow USAF Hospital Andrews AFB Wash DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/18/67	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL BURIAL PARK		23d. LOCATION (City or Town) (County) (State) FORT WORTH TEXAS	
24. FUNERAL DIRECTOR ROBERT E WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND		25a. REC'D BY REGISTRAR DATE NOV 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15933

15925

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 16 <u>03 months</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyattsville Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ALMA</u> First <u>VERNA</u> Middle <u>THORNBURG</u> Last				4 DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1967</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-17-1895</u>	9. AGE (In years last birthday) <u>72</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Stafford County, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Masters</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Wiggington</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-54-7419</u>		17. INFORMANT <u>Hyattsville Nursing Home</u> Address <u>6500 Riggs Road</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1. Congestive Heart Failure</u> DUE TO (b) <u>2. Cerebrovascular Thrombosis</u> DUE TO (c) <u>2 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>11/30</u> , 19 <u>67</u> to <u>11/29</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/29</u> , 19 <u>67</u> , and that death occurred at <u>4:15</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Verma L. Cimeau</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11/29/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Verma L. Cimeau</u>		22d. ADDRESS <u>3503 Penny St Mt Rainier and</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>			
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		ADDRESS <u>Mt. Rainier, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form - PART Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15934

15926

1 PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Harford</u>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>			d STREET ADDRESS <u>Giles Lane Box 203</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Albert</u> Last <u>Tildon</u>			4 DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1967</u>		
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-17-1928</u> 1946 <u>12</u> 20	9 AGE (In years last birthday) yrs <u>18</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>16</u> Hours <u>19</u> Min <u>67</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Havre de Grace, Md.</u>	
13 FATHER'S NAME <u>Morgan E. Tildon</u>			12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16 SOCIAL SECURITY NO <u>212-48-9342</u>		17 INFORMANT <u>Morgan E Tildon</u> Address <u>Aberdeen, Maryland 21001</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Laceration of brain</u> DUE TO <u>Trauma - auto accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Occupant thrown from car after collision with tree.</u>			
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>2:00</u> m <u>11-16-1967</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Race Track Rd. &amp; Old Chapel Rd., Bowie, Md.</u>		
20f (City or town) _____ (County) _____ (State) _____					
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>11-17-67</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>20 Nov 67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Union M.E. Ceme</u>		23d LOCATION (City or town) _____ (County) _____ (State) _____ <u>Aberdeen, Maryland 21001</u>	
24. FUNERAL DIRECTOR <u>Walter W. W. S. Tarring Funeral Home</u>		ADDRESS <u>Aberdeen, Maryland 21001</u>		25a REC'D BY REG. STRAR DATE <u>NOV 22 1967</u>	25b REGISTRAR'S SIGNATURE <u>Judge</u>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**FOR STATE HEALTH DEPT.**

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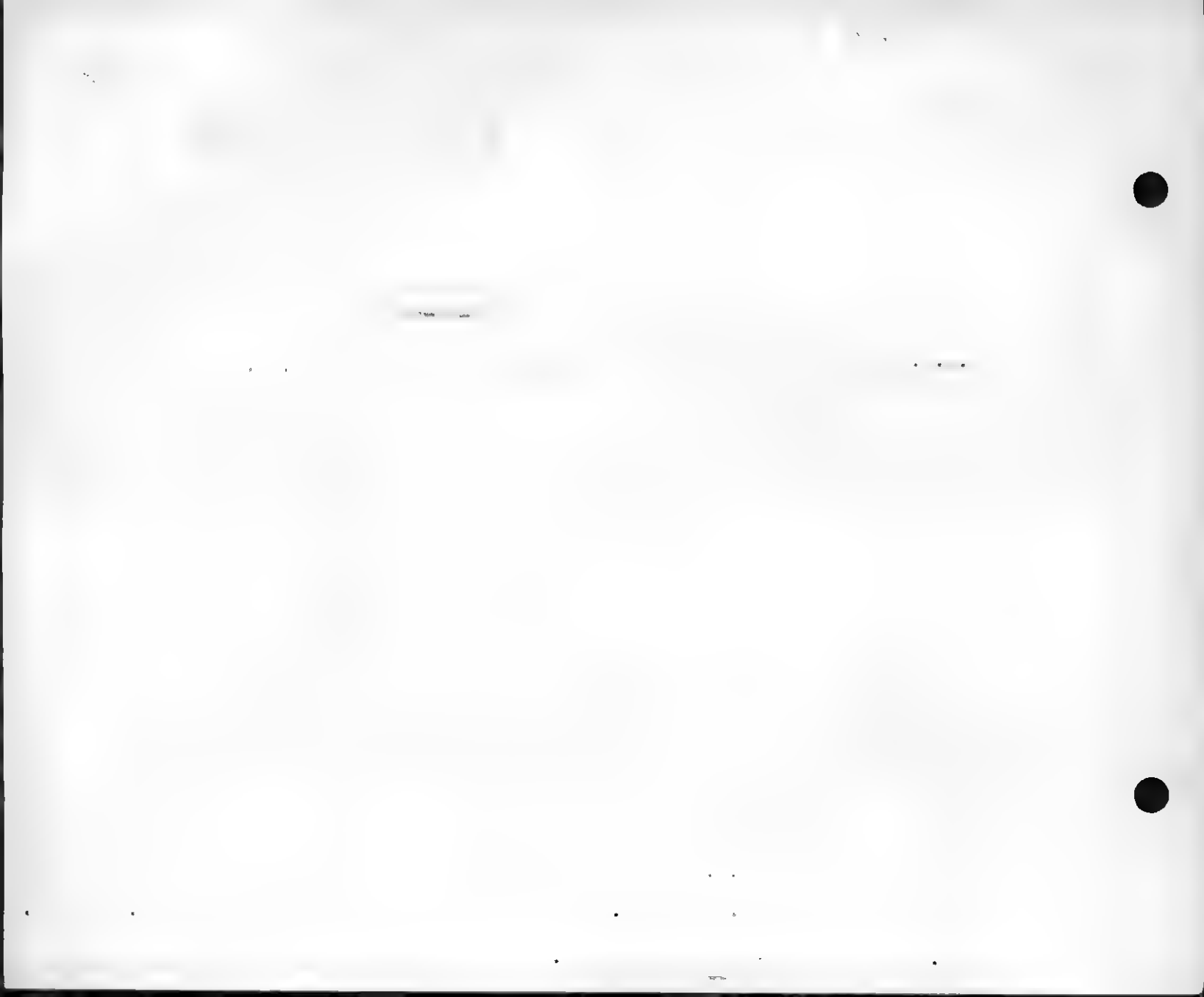
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

15935

15927

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>4009 82nd Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Wade</u> Middle <u>Anthony</u> Last <u>Tippett</u>				4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>19 67</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-31-15</u>		9. AGE (In years last birthday) <u>52</u> yrs	10. UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. UNDER 24 HRS Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>P.B.X. Installer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>C &amp; P Telephone Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>Wilbur Tippett</u>				14. MOTHER'S MAIDEN NAME <u>Alpha Dean</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO <u>578 52 9761</u>		17. INFORMANT <u>Nettie A. Tippett</u>		Address <u>Forestville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year hour a.m. <u>  </u> pm <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John Kehoe M.D., Riverdale, Maryland</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>  </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6 Nov. 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pr. Geo. Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch &amp; Sons - Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR <u>NDV 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MDARYLAND STATE DEPARTMENT OF HEALTH

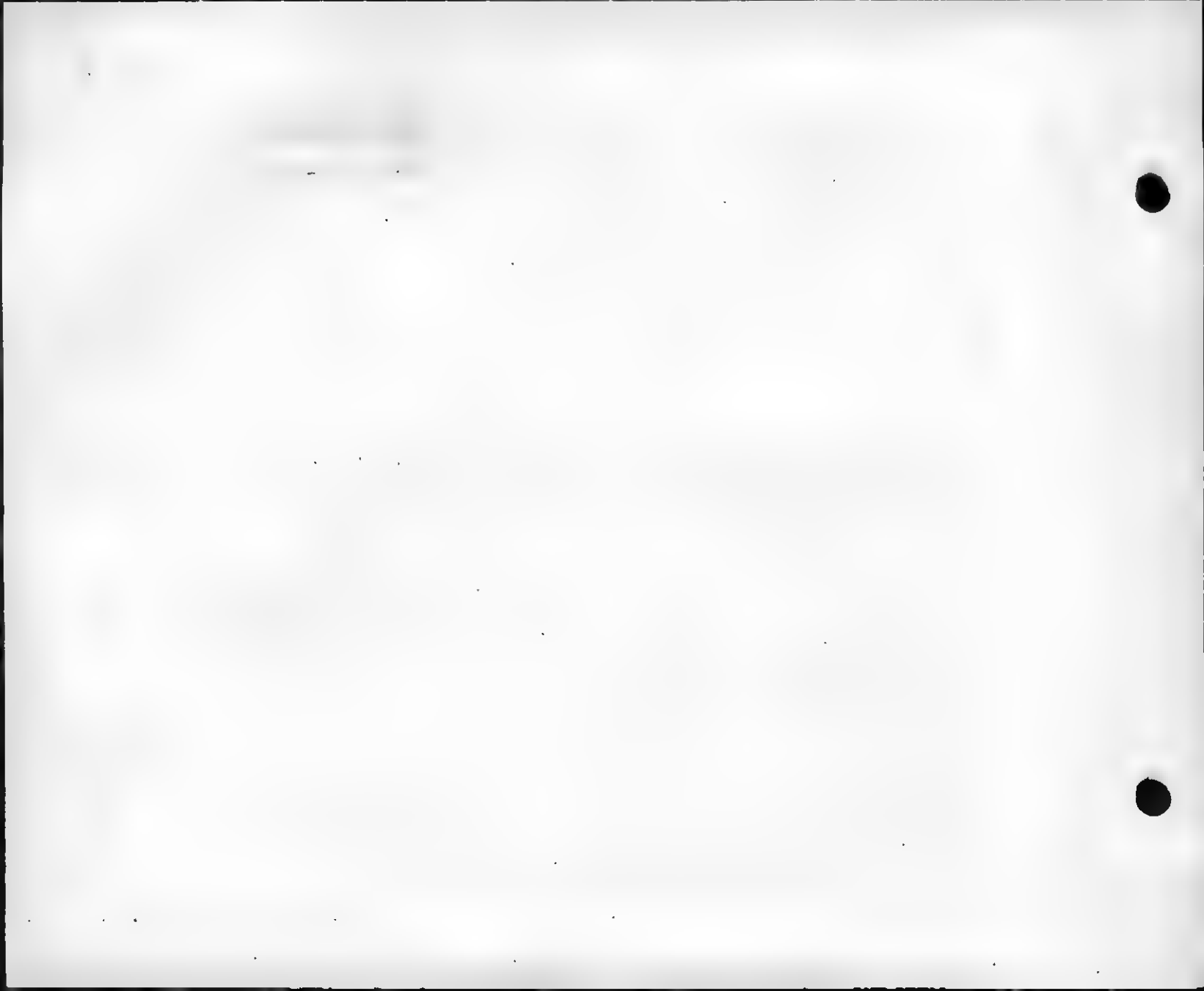
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

25935

CERTIFICATE OF DEATH

10028

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>		c. LENGTH OF STAY IN 1b <u>Since 4/11/66</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greenbelt Convalescent Center</u>		d. STREET ADDRESS <u>6300 Osage Street</u>	
3 NAME OF DECEASED (Type or print) <u>William Edward Townsend</u>		4 DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/29/1900</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Agent Purchasing Office U.S. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Atlantic, N.J.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>William H Townsend</u>		14. MOTHER'S MAIDEN NAME <u>Louise Kreig</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-46-9422</u>	
17. INFORMANT <u>William E. Townsend Same as #2 (Son)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus; Hypercholesterolemia; Past History of CVA</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>  </u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <u>  </u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) (County) (State) <u>  </u>		21. I certify that (1) (this hospital) attended the deceased from <u>July 12, 1966</u> , to <u>Nov 10, 1967</u> , that (1) (we) last saw the deceased alive on <u>11-10-1967</u> , and that death occurred at <u>5:35 PM</u> , from causes and on the date stated above.	
22a. SIGNATURE <u>Alan R Gair</u>		22b. DATE SIGNED <u>11/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alan R Gair M.D.</u>		22d. ADDRESS <u>7777 Maple Ave, Takoma Park, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/14/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor P.G. Md.</u>	
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 396 1-9-68 MARYLAND STATE DEPARTMENT OF HEALTH 15037 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10929											
1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE b. COUNTY Washington, D.C.					
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.				47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital						d. STREET ADDRESS 410 K Street NE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Ernest A. Turner						4 DATE OF DEATH Month Day Year 11 16 1967					
5 SEX male		6 COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH 2-7-11		9 AGE (In years last birthday) 56 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Elberton Ga.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME George Turner						14. MOTHER'S M.A.D.E.N NAME UNKNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO 247-01-3257		17 INFORMANT Hospital Records				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Unknown										INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 2:15pm 11-16 1967				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Box 2316		20f. (City or town) (County) (State) Upper Marlboro, F.G. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Kehoe						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF NOV. 23-67		23c. NAME OF CEMETERY OR CREMATORY CAMP SPRINGS CEM. CEM.				23d. LOCATION (City or town) (County) (State) Elberton Ga.	
24. FUNERAL DIRECTOR UNIVERSAL FUNERAL HOME				ADDRESS 516 H ST NE WASH DC		25a. REC'D BY REGISTRAR DATE NOV 28 1967				25b. REGISTRAR'S SIGNATURE R. J. Jones	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

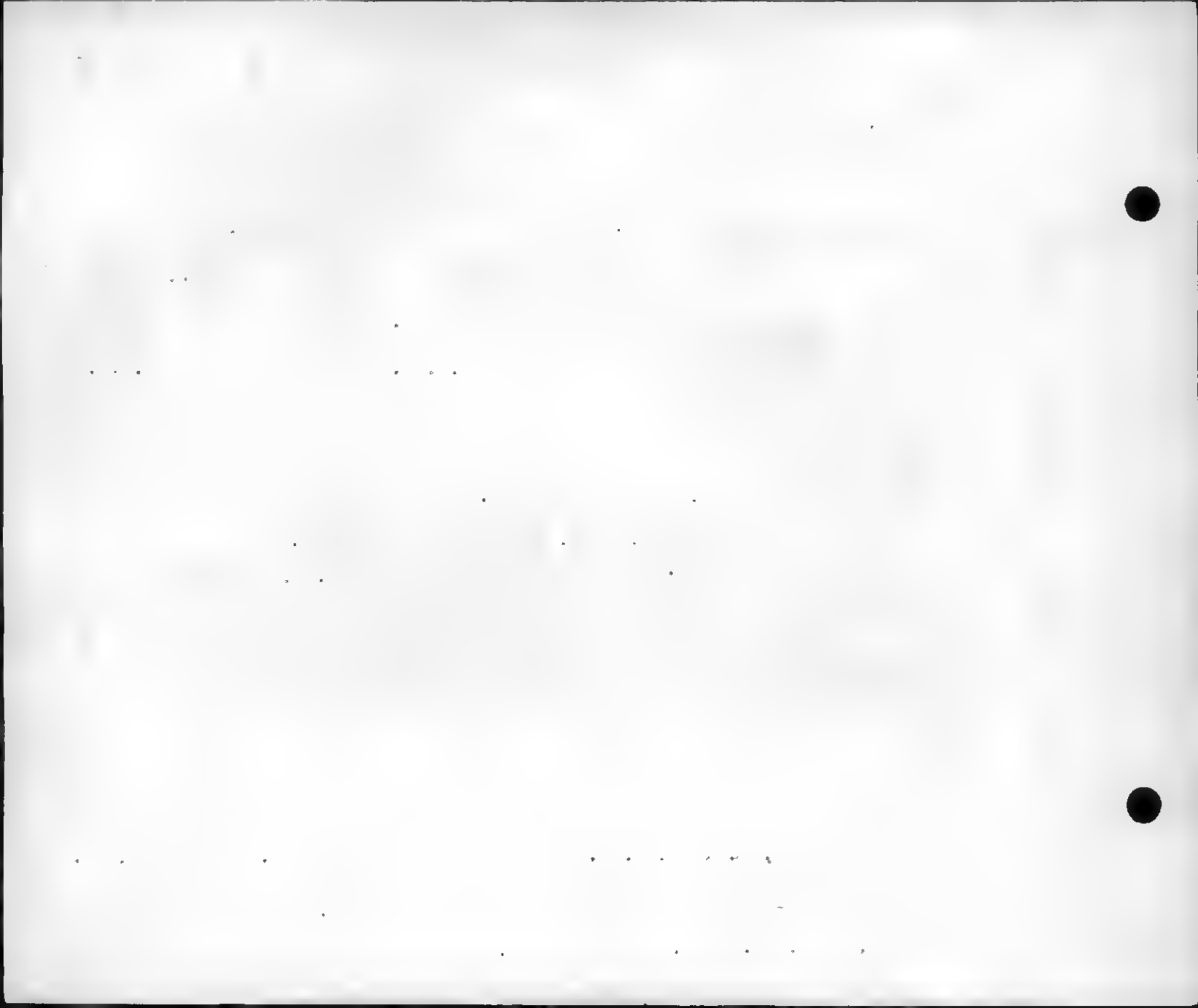
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 13 & 14 taken from birth certificate

CERTIFICATE OF DEATH

17898

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY in 1b <b>6 hrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>3813 64th Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Twynham</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>15</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 Nov., 1967</b>
9. AGE (In years last birthday) <b>6</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State, or foreign country) <b>P.G. Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Alwyn Twynham</b>		14. MOTHER'S MAIDEN NAME <b>Carolyn Gail Finley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>1. Hydrocephalus 2. Congenital cystic hydroma,</b> DUE TO <b>thorax, neck, right upper extremity.</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3. Diffuse gliosis of cerebrum. 4 Respiratory</b> DUE TO <b>distress syndrome</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>this doctor</del> attended the deceased from <b>Nov. 14, 1967</b> to <b>Nov. 15, 1967</b> , that (I) <del>was</del> last saw the deceased alive on <b>Nov. 15, 1967</b> , and that death occurred at <b>3:10 AM</b> from causes and on the date stated above			
22a. SIGNATURE <b>John W. Perkins</b>		22b. DATE SIGNED <b>11-15-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John W. Perkins, M. D.</b>		22d. ADDRESS <b>6201 Riverdale Rd., Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>12-23-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hosp. Cheverly, Maryland</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Robert W. Penn, Jr., Adm.</b>		25a. REC'D BY REGISTRAR <b>Cheverly, Md.</b>	
25b. REGISTRAR'S SIGNATURE		DATE <b>JAN 2 1968</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15938

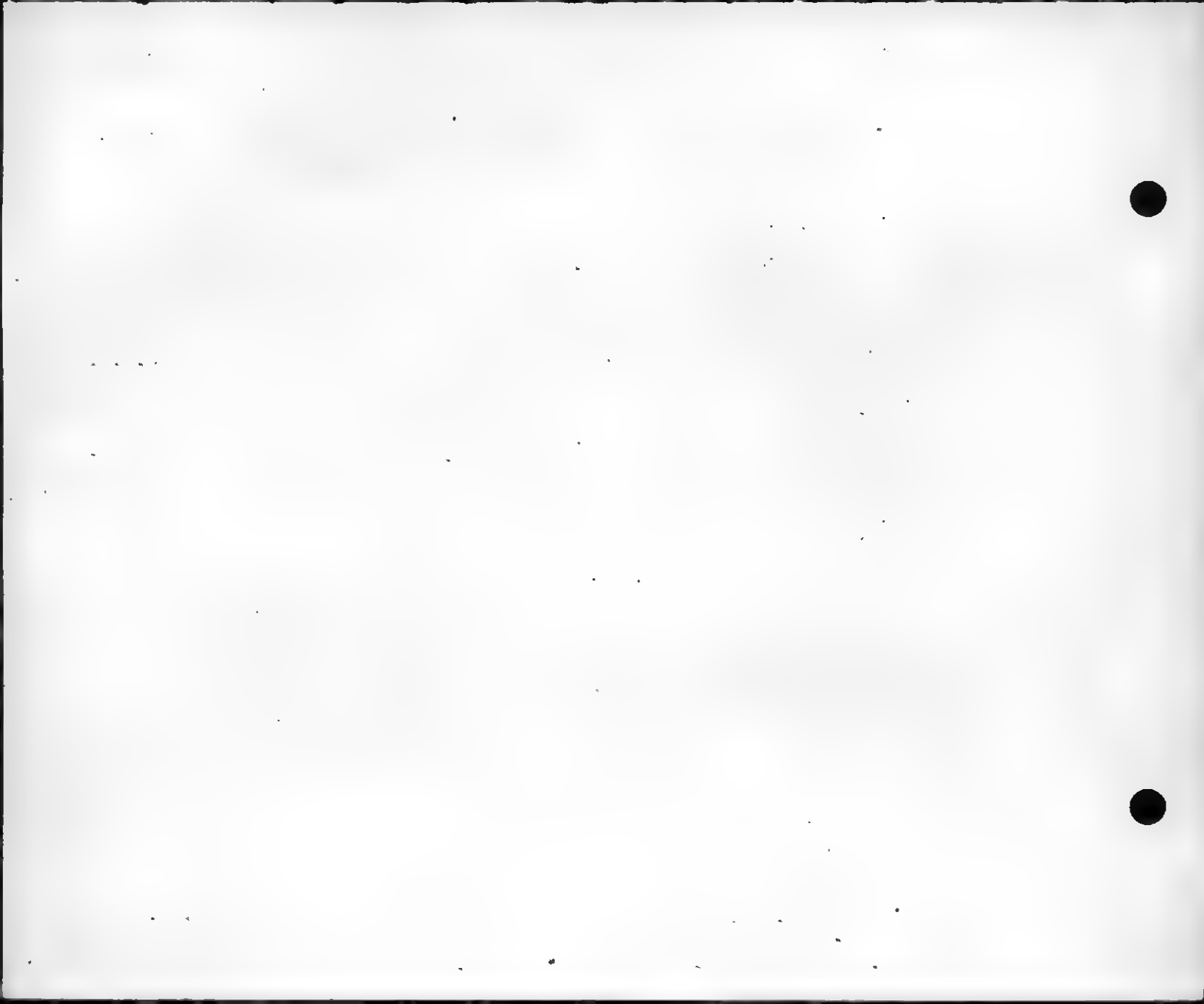
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15520

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>16 Months</u>				d. STREET ADDRESS <u>1025 Janley Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greenbelt Convalescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Gertrude</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 21, 1881</u>	
9. AGE (in years last birthday) <u>86</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Covington, Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Emmanuel C. Peach</u>			
14. MOTHER'S MAIDEN NAME <u>Cecelia</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>229-44-1401</u>				17. INFORMANT <u>Ralph C. Van Allen</u> Address <u>1025 Janley Road Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Cerebro-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diverticulitis of Colon</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIONS GIVEN IN PART I (a) <u>Generalized Arteriosclerosis Metabolic Arteritis Generalized</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (i) (this hospital) attended the deceased from <u>May 7, 1965</u> to <u>Nov 20, 1967</u> , that (ii) (we) last saw the deceased alive on <u>Nov 18, 1967</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>George L. Ball</u>				22b. DATE SIGNED <u>Nov 20 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u>				22d. ADDRESS <u>10620 Georgia Ave Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 22, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Nov 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		25c. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

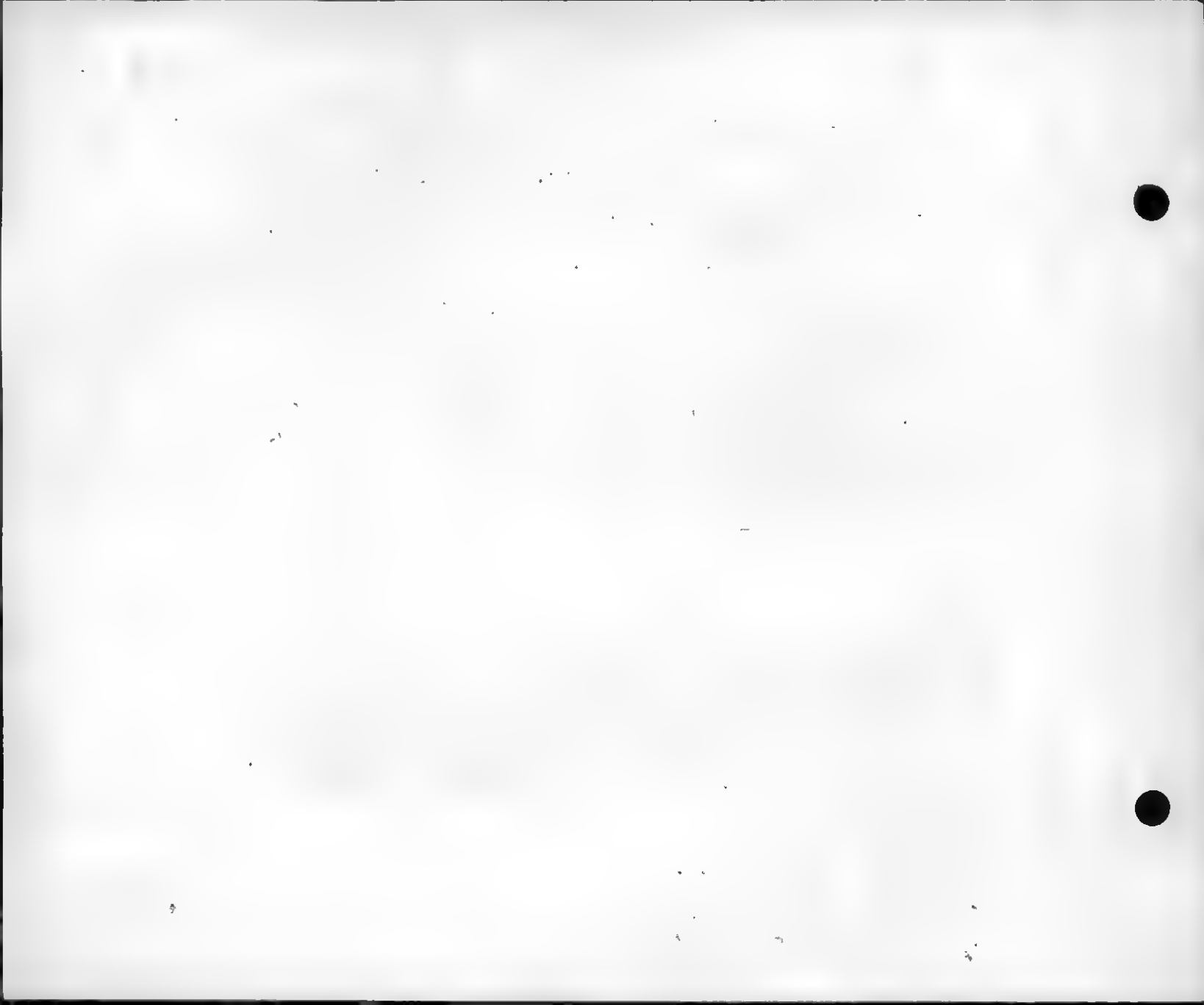
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15931

15931

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>10 hrs.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>3358 Chillum Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>R.</b> Last <b>Van Dolsen</b>				4. DATE OF DEATH Month <b>November</b> Day <b>24</b> , Year <b>19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/21/96</b>	
9. AGE (In years last birthday) <b>71</b> yrs		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b>		11. IF UNDER 24 HRS Hours <b>4</b> Min <b>30</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVERNMENT</b>		11. BIRTHPLACE (County & State, or foreign country) <b>INDIANA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>ALBERT VAN DOLSEN</b>				14. MOTHER'S MAIDEN NAME <b>SARAH DEVORE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES W.W.I</b>				16. SOCIAL SECURITY NO. <b>094057494A</b>		17. INFORMANT <b>MRS ROSEMARY McLAUGHLIN</b> Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LUBAR PNEUMONIA and</b> <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>CONGESTIVE HT FAILURE</b> DUE TO (c) <b>ASTHMA</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 day</b> <b>4 hr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>62</b> to <b>Nov. 24</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>11-24</b> 19 <b>67</b> and that death occurred at <b>9:30 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>John Kehoe</b> M.D.				22b. DATE SIGNED <b>11-25-67</b>		22c. PHYSICIAN'S NAME (Type) <b>John Kehoe M.D.</b>	
22d. ADDRESS <b>Riverdale, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)	
<b>CREMATION</b>		<b>Nov 27, 1967</b>		<b>FORT LINCOLN</b>		<b>COLMAR MANOR, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO</b>				ADDRESS <b>RIVERDALE, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

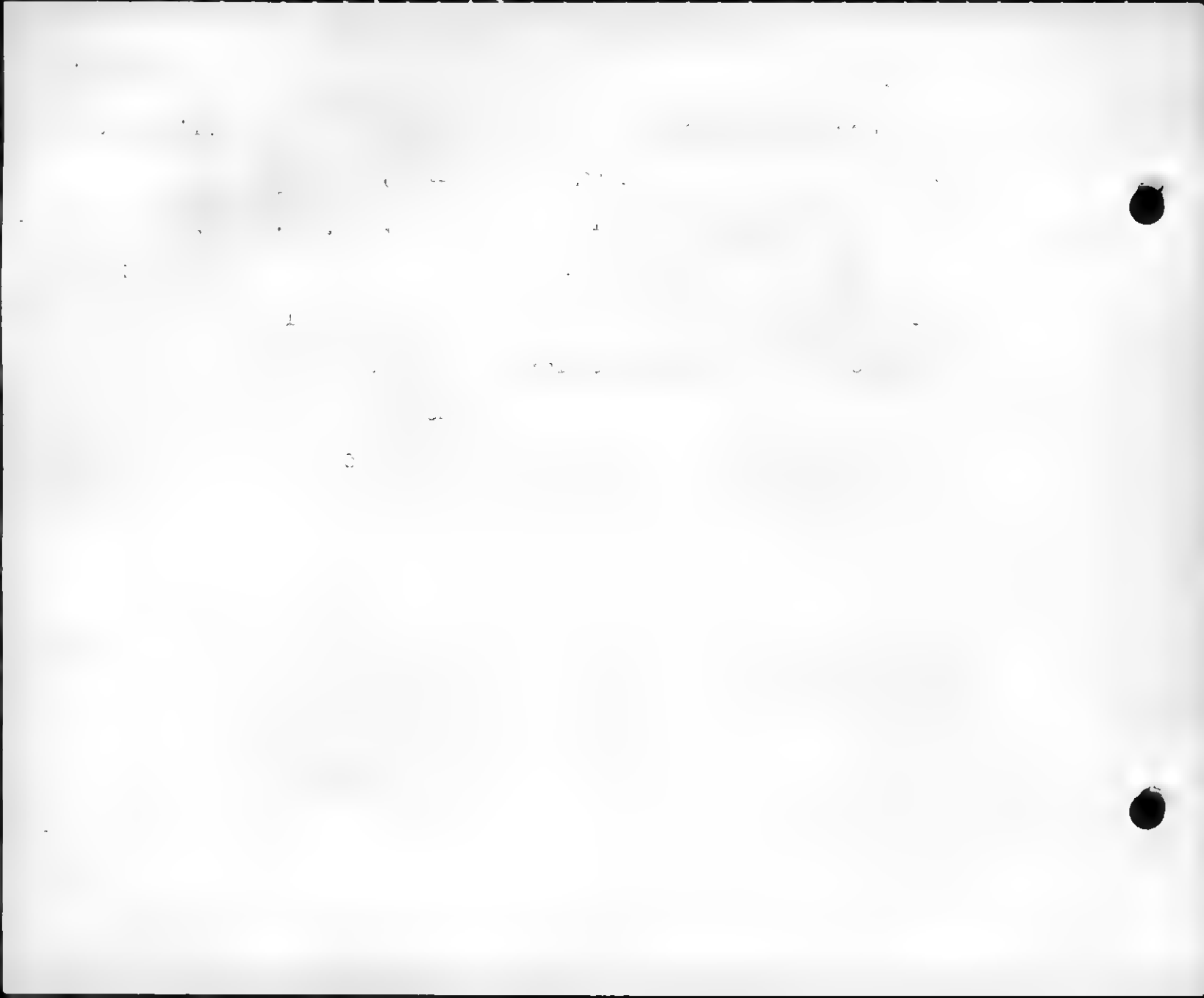
VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10932

1 PLACE OF DEATH a. COUNTY <b>Prince George's County</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) c. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chillum, Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>		d. STREET ADDRESS <b>1308 Chillum Road</b> <del>4408 Quince Orchard Rd., Riverdale</del>	
3 NAME OF DECEASED (Type or print) <b>James C. Walsh</b>		4 DATE OF DEATH Month <b>11</b> Day <b>12</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6-4-96</b>
9 AGE (In years lost birthday) <b>71</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DC Post Office</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>England</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Matthew N</b>		14. MOTHER'S MAIDEN NAME <b>Alice Gath</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>577 10 3111</b>	
17. INFORMANT <b>Admitting Record</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>4501</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ATRIAL FIBRILLATION</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>JULY</b> , 19 <b>62</b> , to <b>12 NOV</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12 NOV</b> 19 <b>67</b> , and that death occurred at <b>11 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>C. J. Hoomann</b>		22b. DATE SIGNED <b>12-NOV-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. J. HOOMANN</b>		22d. ADDRESS <b>RIVERDALE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 16, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Prp Geo Md.</b>
24 FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>NOV 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15933

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN 1b 5 yrs. 10 mo.		d. STREET ADDRESS 114 Eldred Drive <del>23408 Monocacy Drive</del>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Julia B. Walsh		4 DATE OF DEATH Month Day Year November 19 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1885
9. AGE (In years lost birthday) yrs 82		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York City, N.Y.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Charles Blum		14. MOTHER'S MAIDEN NAME Elizabeth Dort	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 125-18-5644	
17. INFORMANT. Address J. Walsh 114 Eldred Dr., S. S., Md.		Sacred Heart Home, Hyattsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4201 CORONARY THROMBOSIS C MYOCARDIAL INFARCTION DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) HYPERTENSIVE HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 1 day 6 YEARS 6 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from APRIL 20, 1961, to NOV 19, 1967, that (I) (we) last saw the deceased alive on NOV 18, 1967, and that death occurred at 2:30 P.M., from causes and on the date stated above.			
22a. SIGNATURE Thomas F. Collins M.D.		22b. DATE SIGNED 11-19-67	
22c. PHYSICIAN'S NAME (Type) THOMAS F. COLLINS		22d. ADDRESS 322 - H. H. NE	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Nov. 21, 1967	23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	23d. LOCATION (City or Town) (County) (State) Forest Glen, Maryland
24. FUNERAL DIRECTOR Thomas J. Thomas, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR: NOV 22 1967 DATE	
25b. REGISTRAR'S SIGNATURE			



## CERTIFICATE OF DEATH

Reg. Dist. No.

334

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxen Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxen Hill MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1405 Southern Ave</u>				d. STREET ADDRESS <u>1405 Southern Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>LEONA</u> Middle <u>S.</u> Last <u>WALSH</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 21, 1888</u>	
9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>AUGUST SCHWARTZENTRUB</u>				14. MOTHER'S MAIDEN NAME <u>ALVA M. Bliss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>577-14-8679</u>		17. INFORMANT <u>Dr. Baker Herbert</u> Address <u>Skim</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Cerebral Arteriosclerosis</u> (b) <u>4201</u> DUE TO <u>Cerebral Arteriosclerosis</u> (c) <u>4201</u> DUE TO <u>Cerebral Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent Cerebral Vascular Accident</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/15</u> 19 <u>67</u> to <u>11/1</u> 19 <u>67</u> , that I last saw the deceased alive on <u>11/1</u> 19 <u>67</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>4400 Stamp Rd. #6</u> DATE SIGNED <u>NOV 6 1967</u>			
PHYSICIAN'S NAME (Type) <u>I. T. O. DONOVAN</u>				<u>WASH. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Nov 4, 1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	
22d. LOCATION (City, town, or county) <u>Wash D.C.</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter 3603</u>				ADDRESS <u>12th St NW</u>		24a. REC'D BY REGISTRAR <u>NOV 6 1967</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

15943  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15935

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>24 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Princed Georges General Hospital</b>		d. STREET ADDRESS <b>828 49th Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>W</b> Last <b>Wandschneider</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>21</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept., 1906</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>coal minor</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hamburg Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b> Address <b>Cheverly, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>157X</b> DUE TO <b>Cause of Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Oct. 29, 1967</b> , to <b>Nov. 21, 1967</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 21, 1967</b> , and that death occurred at <b>12:55 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Arnold G. Brody, M.D.</b>		22b. DATE SIGNED <b>Nov. 22, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 24, 1967</b>	23c. NAME OF CEMETERY OR CREMATOR <b>National</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15944

15936

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>				c. LENGTH OF STAY IN It			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens Health Care Center</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>B</u> Last <u>Wardner</u>				4. DATE OF DEATH <u>Nov 16 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-7-89</u>	
9. AGE (In years, months, days, hours, minutes) <u>78</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Bowie JAMES A. BOWIE</u>				14. MOTHER'S MAIDEN NAME <u>SUSANA WARD SIMMONS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-28-9528 DA-B</u>		17. INFORMANT <u>Mrs Margaret Grimes Box 4311 Upper Marlboro Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO <u>PULMONARY EDEMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PNEUMONIA</u> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>11/16</u> 19 <u>67</u> , and that death occurred at <u>3:10 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <u>11/16/67</u>			
22c. PHYSICIAN'S NAME (Type) _____				22d. ADDRESS <u>11200 LOCKWOOD DR SILVERSPRING MD</u>			
23a. BURIAL, CREMATION, OR OTHER DISPOSAL <u>Burial</u>		23b. DATE THEREOF <u>11/19/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Park Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Marbury, Maryland</u>	
24. FUNERAL DIRECTOR <u>Archard Funeral Home LaPlata, Md</u> ADDRESS _____				25a. REC'D BY REGISTRAR <u>NOV 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY PRINCE GEORGES MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LAUREL  
c. LENGTH OF STAY IN 1b 3 DAYS  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Laurel General Hospital, Inc.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE MARYLAND b. COUNTY MONTGOMERY  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GARRETT PARK  
d. STREET ADDRESS 4509 Oxford Street  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) FRANK L. WEAVER  
4. DATE OF DEATH November 12 1967  
5. SEX Male 6. COLOR OR RACE Caucasian 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH 21 July 1891  
8. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months 12 Days 12 IF UNDER 24 HRS.: Hours 12 Min. 00

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer  
10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.  
11. BIRTHPLACE (County & State, or foreign country) U. S.  
12. CITIZEN OF WHAT COUNTRY? U. S.  
13. FATHER'S NAME Lloyd Everett Weaver  
14. MOTHER'S MAIDEN NAME Mary Ella Ragan  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 378-16-3794 17. INFORMANT Wife Elizabeth D. Weaver Address Same as Item 2.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Arteriosclerosis  
DUE TO (b) Diabetes mellitus, adult-onset type  
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) Cirrhosis of liver; portal hypertension 7 years.  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Cirrhosis of liver; portal hypertension 7 years.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒  
INTERVAL BETWEEN ONSET AND DEATH 3 years  
6 years

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)

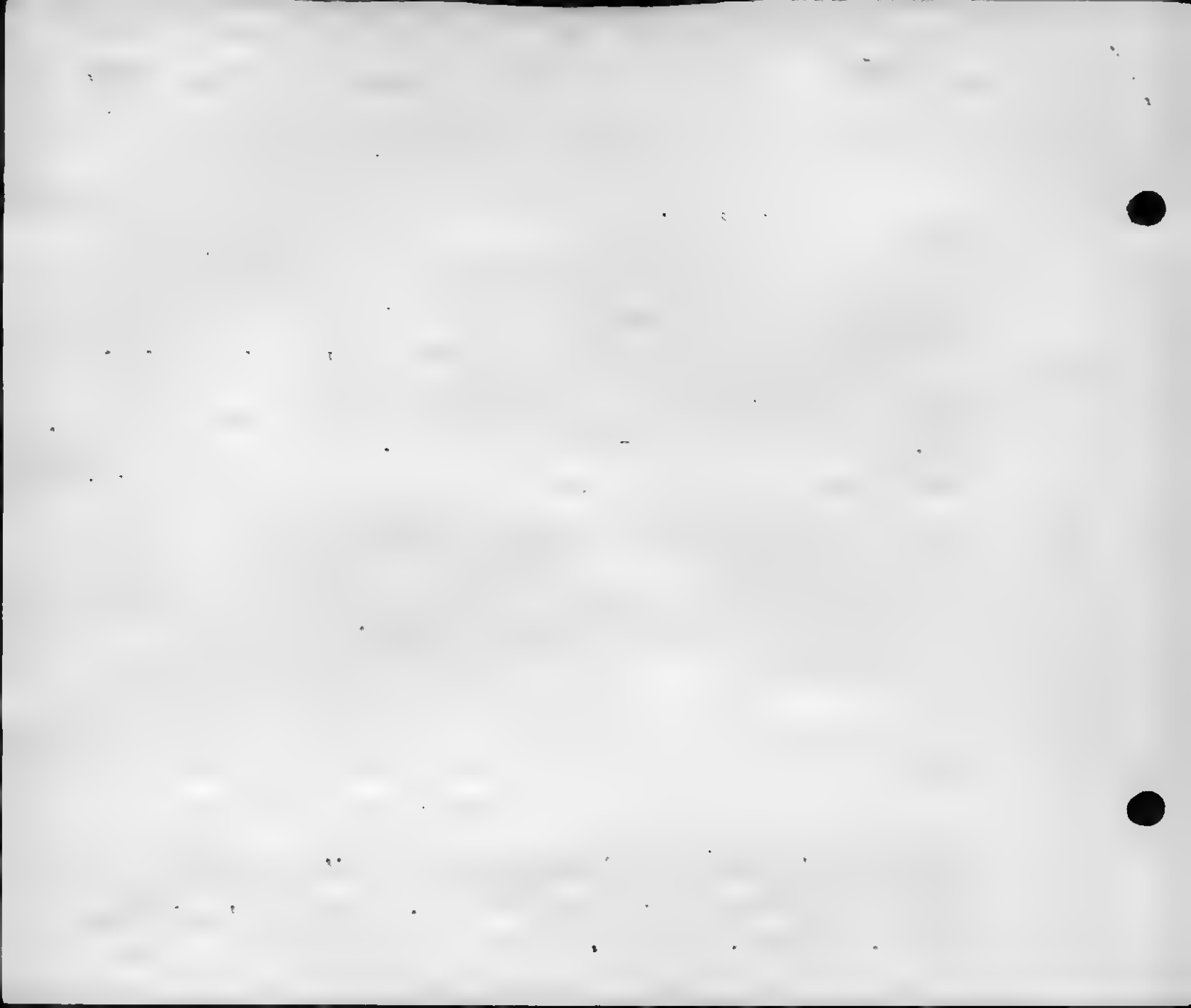
21. I certify that (I) (this hospital) attended the deceased from 12 Nov 1967 to 12 November 1967, that (I) (we) last saw the deceased alive on 12 Nov 1967, and that death occurred at 6:30 AM from the causes and on the date stated above.

22a. SIGNATURE Richard Compton M.D. 22b. DATE SIGNED 12 Nov 67  
22c. PHYSICIAN'S NAME (Type) J. Richard Compton, MD 22d. ADDRESS 612 Main St., Laurel, Maryland 20810

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11-15-67 23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem. 23d. LOCATION (City, town or county) (State) Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland ADDRESS Bethesda, Maryland 25a. REC'D BY REGISTRAR NOV 14 1967 25b. REGISTRAR'S SIGNATURE James Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



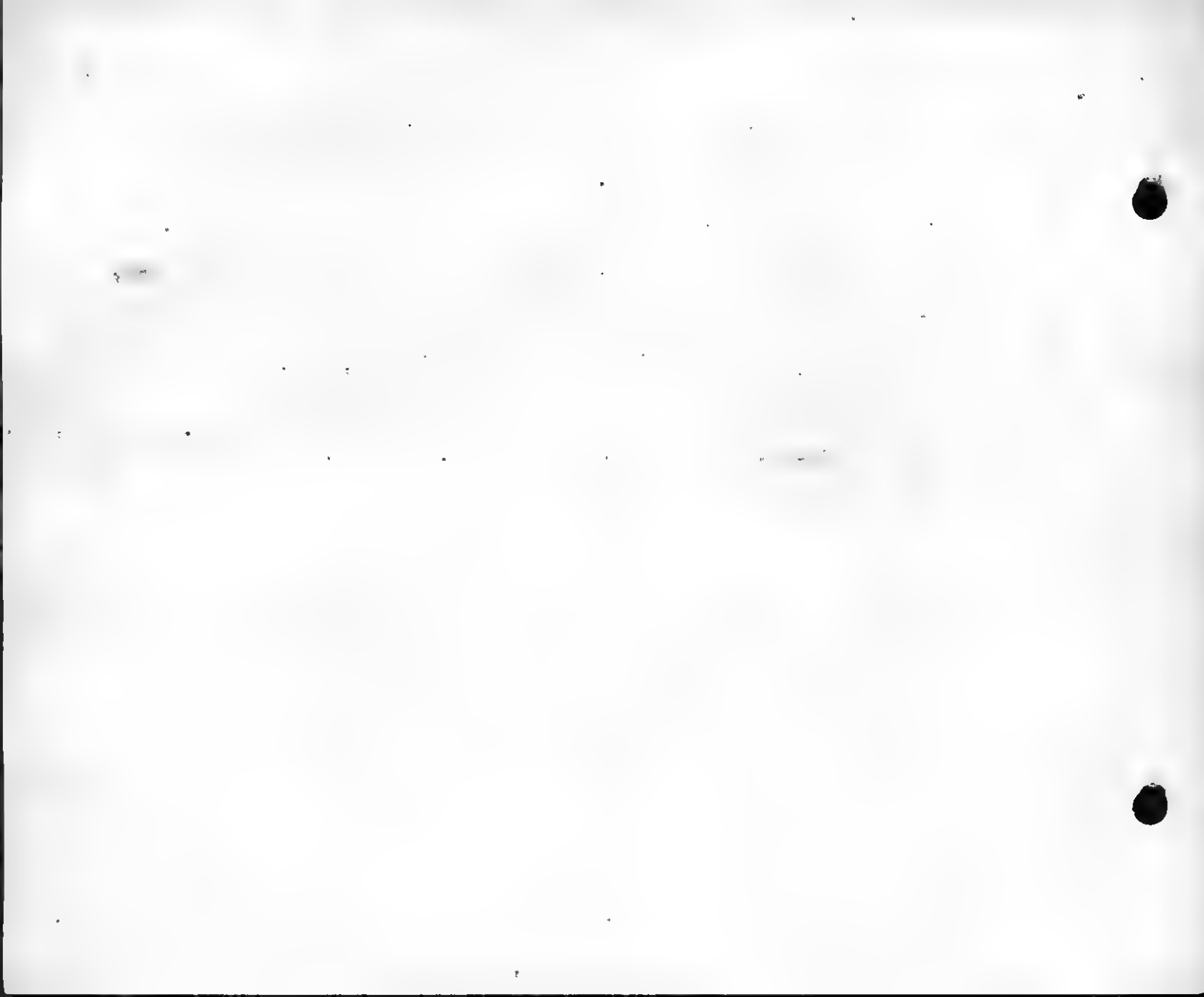
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>2yrs. 10 M</b>		d. STREET ADDRESS <b>3225 Hiatt Place, N.W.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Manor 4922 LaSalle Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Josephine G. Weber</b>		4. DATE OF DEATH Month Day Year <b>November 30, 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/16/81</b>
9. AGE (In years last birthday) <b>86</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min. <b>9 14</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Leonard Weber</b>		14. MOTHER'S MAIDEN NAME <b>Mary Dittmeyer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>579-60-1033</b>	
17. INFORMANT <b>Mrs. Clyde W. Hammerbacher-sister</b>		18. ADDRESS <b>4413 Highland Ave. Bethesda, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Heart Disease</b> DUE TO (c) <b>2 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>this hospital</del> attended the deceased from <b>April 29, 19 65</b> , to <b>Nov. 30, 19 67</b> , that (I) <del>we</del> last saw the deceased alive on <b>Nov. 30, 19 67</b> , and that death occurred at <b>9p</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Thomas F Collins</b>		22b. DATE SIGNED <b>Dec. 1, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas F Collins, M.D.</b>		22d. ADDRESS <b>322 H St. N.E. Washington, D.C. 20002</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/4/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's</b>	23d. LOCATION (City or town) (County) (State) <b>Harpers Ferry W. Va.</b>
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		25. REC'D BY REGISTRAR <b>DEC 6 1967</b>	
26. ADDRESS <b>1331 Rockville Pike Rockville, Maryland</b>		27. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	




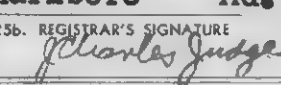
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15945

620

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo's</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN <b>1 Mo., 2 Days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL-Upper Marlboro</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>Gen. Delivery</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Wedge</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>30</b> Year <b>1967</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>April 23, 1892</b>	<b>9. AGE</b> (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR: Months <b>75</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Gardening Work</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>			
<b>13. FATHER'S NAME</b> <b>John Ed. Wedge</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Eleanor Jackson</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes. W.W.I.</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Gen. Delivery</b> <b>Sarah H. Wedge- Upper Marlboro, Md.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myemia</b> DUE TO (b) <b>Stroke &amp; peritonitis</b> (c) <b>Ruptured appendix</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr Angiogenesis Leukemia</b>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>21a. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.	<b>21b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>21c. PLACE OF INJURY</b> (Home, farm, lecture, street, office bldg., etc.)	<b>21d. (City or town)</b>	<b>21e. (County)</b>	<b>21f. (State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from <u>9 hr</u> <u>1967</u> to <u>30 hr</u> <u>1967</u> that (I) (we) last saw the deceased alive on <u>30 hr</u> <u>1967</u> and that death occurred at <u>31 hr</u> <u>1967</u> from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> 		<b>22b. DATE SIGNED</b> <b>11/30/67</b>	<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Robert B. Sasser, M. D.</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12/5/67</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Carmel Cemetery</b>	<b>23d. LOCATION (City, town or county)</b> <b>Upper Marlboro</b>	<b>23e. (State)</b> <b>Md.</b>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Ritchie Bros. Upper Marlboro, Md. 20870</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DEC 8 1967</b>	<b>25b. REGISTRAR'S SIGNATURE</b> 				

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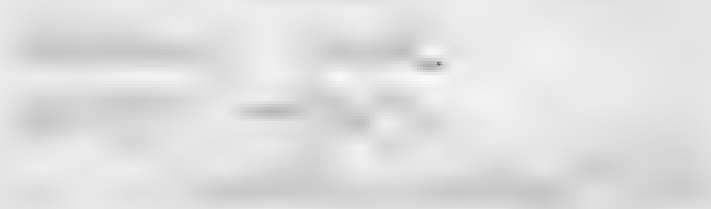
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

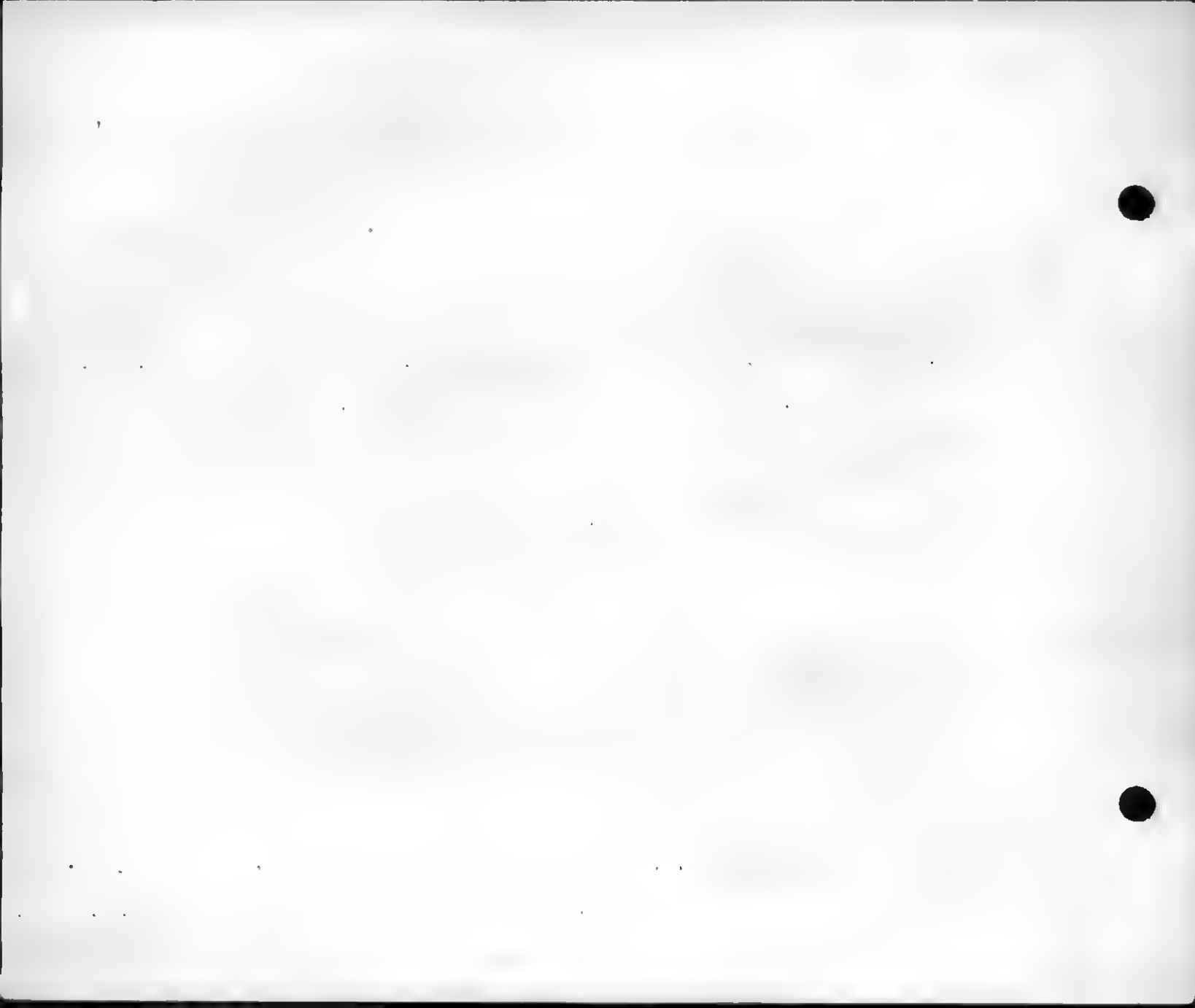
CERTIFICATE OF DEATH

15939

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>3800 56th. Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>J</b> Last <b>Welch</b>		4. DATE OF DEATH Month <b>11</b> Day <b>9</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-1898</b>
9. AGE (In years and months) <b>69 yrs.</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>9</b>	11. IF UNDER 24 HRS Hours <b>19</b> Min. <b>67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Automotive Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile Mfg.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Michael H. Welch</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Fitzpatrick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>121 12 5147</b>	
17. INFORMANT <b>Virginia Welch Same as # 2 (wife)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>And uremia</b> DUE TO <b>And Cerebro vascular occlusion</b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>over 5 yrs</b> <b>5 days</b> <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>57</b> to <b>11-9-</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-9-</b> , 19 <b>67</b> , and that death occurred at <b>11:00 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>John Kehoe</i>		22b. DATE SIGNED <b>11-10-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John Kehoe, M.D.</b>		22d. ADDRESS <b>6300 Riverdale Rd., Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/13/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.G. Md.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		25a. REC'D BY REG. STRAR <b>NOV 13 1967</b>	
ADDRESS <b>Hyattsville, Maryland</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

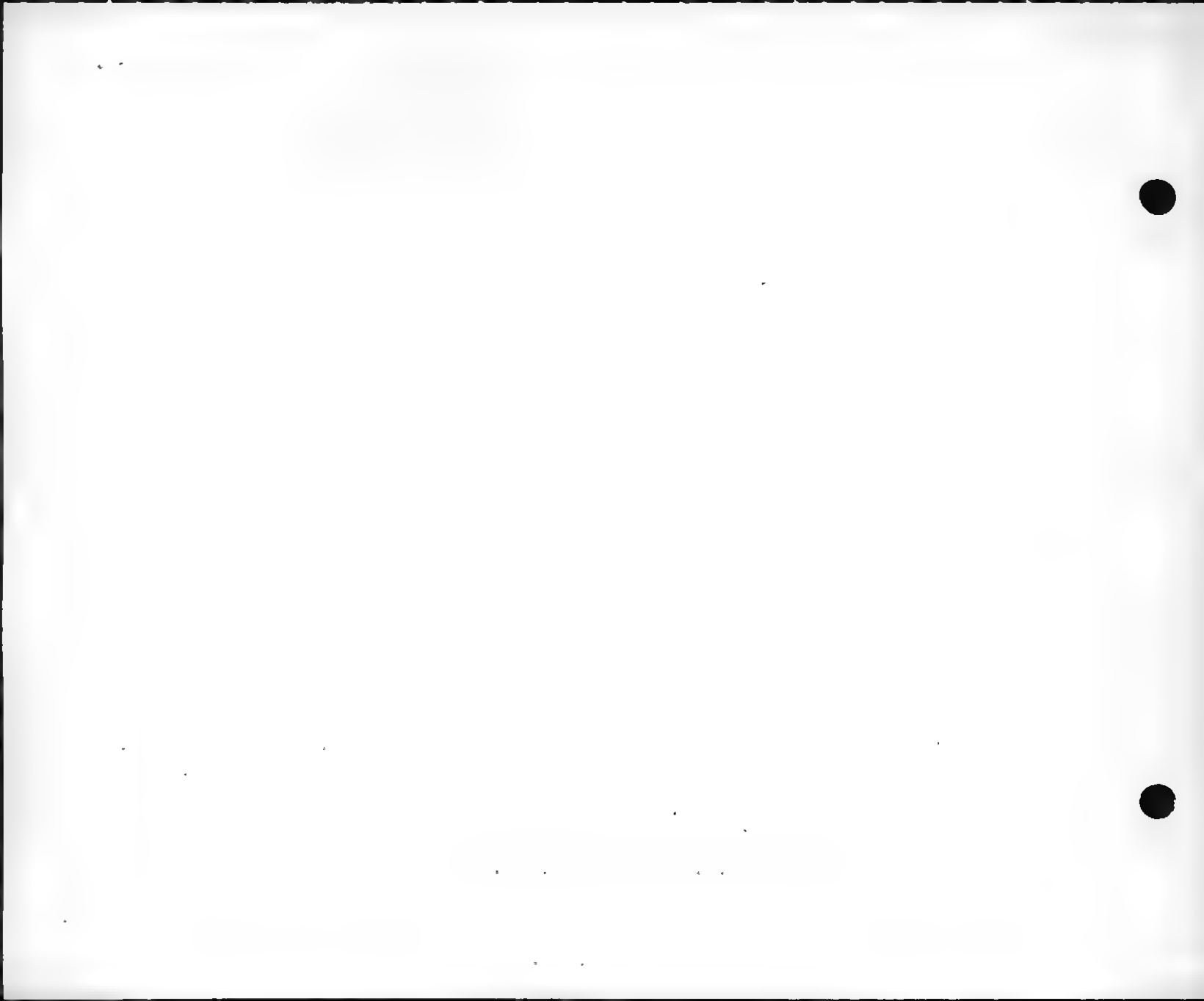
VR A15ME (5)  
6M 1/66

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15640

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		d. STREET ADDRESS <b>7628 Albroath Road</b>	
3 NAME OF DECEASED (Type or print) First <b>Linda</b> Middle <b>Werking</b> Last <b>Werking</b>		4 DATE OF DEATH Month <b>11</b> Day <b>15</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>14 May 1953</b>
9 AGE (In years last birthday) <b>14</b>		10 IF UNDER 1 YEAR Months <b>1</b> Days <b>15</b> Hours <b>16</b> Min. <b>1</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11 BIRTHPLACE (State or foreign country) <b>Md</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Philip N Werking</b>		14 MOTHER'S MAIDEN NAME <b>Annie L Armstrong</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Hospital records</b>		Address <b>Riverdale, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> DUE TO <b>Trauma auto accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Passenger in car involved in collision</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>12:55am</b> <b>11-5-</b> <b>1967</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>4900 Powder Mill Rd., Beltsville, Md.</b>		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>11-15-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>Nov 17, 1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>
24. FUNERAL DIRECTOR <b>F, Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a REC'D BY REGISTRAR <b>NOV 17 1967</b>		25b REGISTRAR'S SIGNATURE <b>William Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

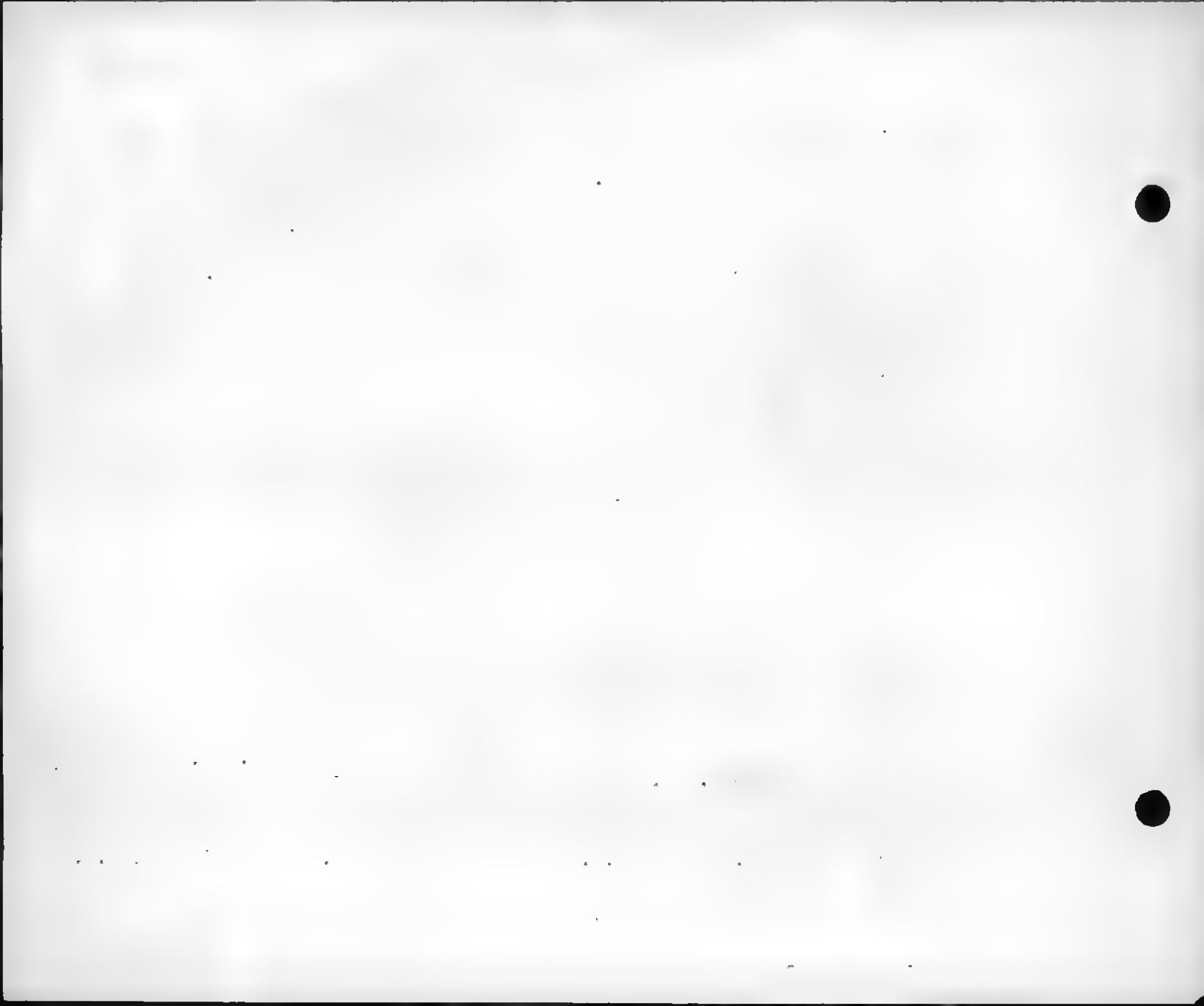
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15850  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15941

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>5hrs.50mins</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b> d. STREET ADDRESS <b>9513 Worrell Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frank - Whedbee</b>			4. DATE OF DEATH Month Day Year <b>Nov. 28, 19 67</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/24/06</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			
13. FATHER'S NAME <b>Samuel Whedbee</b>			14. MOTHER'S MAIDEN NAME <b>Annie Chauncey</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>717 07 8558</b>		17. INFORMANT <b>Edith Whedbee</b> Address <b>Lanham, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>5810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Ruptured Esophageal varices</b> (c) <b>Cirrhosis of the Liver</b>					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <b>Nov 28</b> , 19 <b>67</b> , to <b>Nov. 28</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov. 28</b> , 19 <b>67</b> , and that death occurred at <b>12:50</b> , from causes and on the date stated above							
22a. SIGNATURE <b>Robert T. Kelley, M.D.</b>			22b. DATE SIGNED <b>PM</b>				
22c. PHYSICIAN'S NAME (Type) <b>Robert T. Kelley, M.D.</b>			22d. ADDRESS <b>1302 18th St., NW, Washington, D.C.</b>				
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/1/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, P.G. Md.</b>			
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Maryland</b>			25a. REC'D BY REGISTRAR <b>DEC 5 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

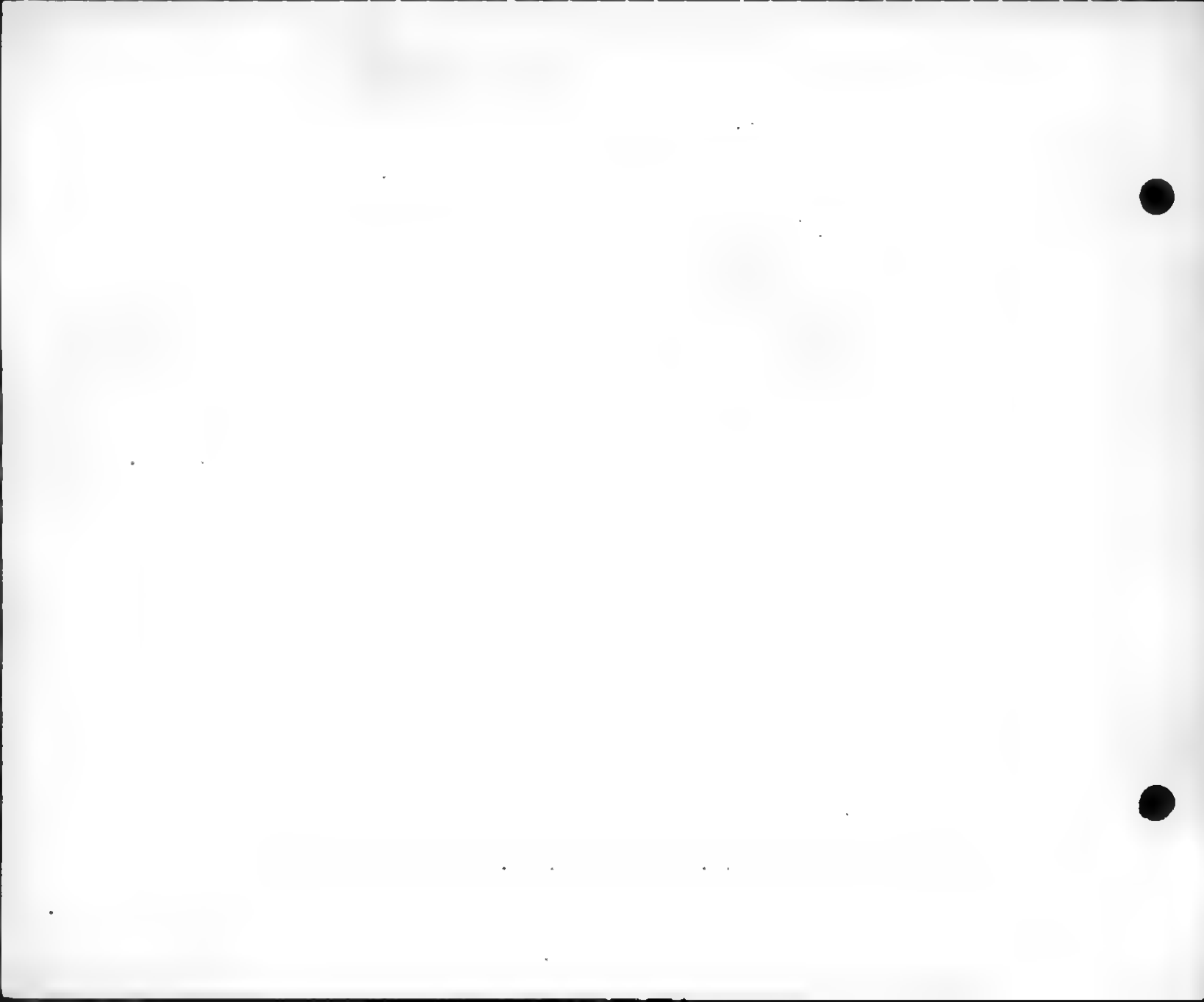
FOR STATE  
HEALTH DEPT.

15951

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15042

1. PLACE OF DEATH a COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) (Institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Prince George's</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c LENGTH OF STAY IN 1b <b>DOA</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's General Hospital</b>		d STREET ADDRESS <b>5102 Byers Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Ira White</b>		4. DATE OF DEATH Month Day Year <b>11 14 19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-16-1922</b>
9 AGE (In years last birthday) <b>45</b> yrs		IF UNDER 1 YEAR Months Days Hours Min. <b>11 14 19 67</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Food Clerk</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Store</b>	
11 BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis G White</b>		14. MOTHER'S MAIDEN NAME <b>Martha N. Mulchi</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W W II</b>		16 SOCIAL SECURITY NO <b>577 26 3419</b>	
17 INFORMANT <b>Shirley M Hall</b>		Address <b>Oxen Hill, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> 103.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Compression of anterior neck</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fell thru kitchen wall partition and injured neck</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>noon 11-14 1967</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Boulevard Hgts P.C. Md.</b>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>11-15-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>Nov 17, 1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	23d LOCATION (City or town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>
24 FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>		25a REC'D BY REGISTRAR DATE <b>NOV 20 1967</b>	
		25b REGISTRAR'S SIGNATURE <b>Officer Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens Health Care Center</u>		d. STREET ADDRESS <u>5527 OXON HILL RD.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph ALVIN Williams</u>		4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 2 1876</u>
9. AGE (In years last birthday) <u>91</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Government</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Charles County - Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-34 6137A</u>	
17. INFORMANT <u>LORRAINE YOW</u>		Address <u>OXON HILL, Md.</u> <u>5525 OXON HILL Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-9</u> , 19 <u>67</u> , to <u>11-3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-3</u> , 19 <u>67</u> , and that death occurred at <u>9:20</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin M.D.</u>		22b. DATE SIGNED <u>11-3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN M.D.</u>		22d. ADDRESS <u>CLINTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/6/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>PRINCE GEORGES, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u> <u>4308 Suitland Road Suitland Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

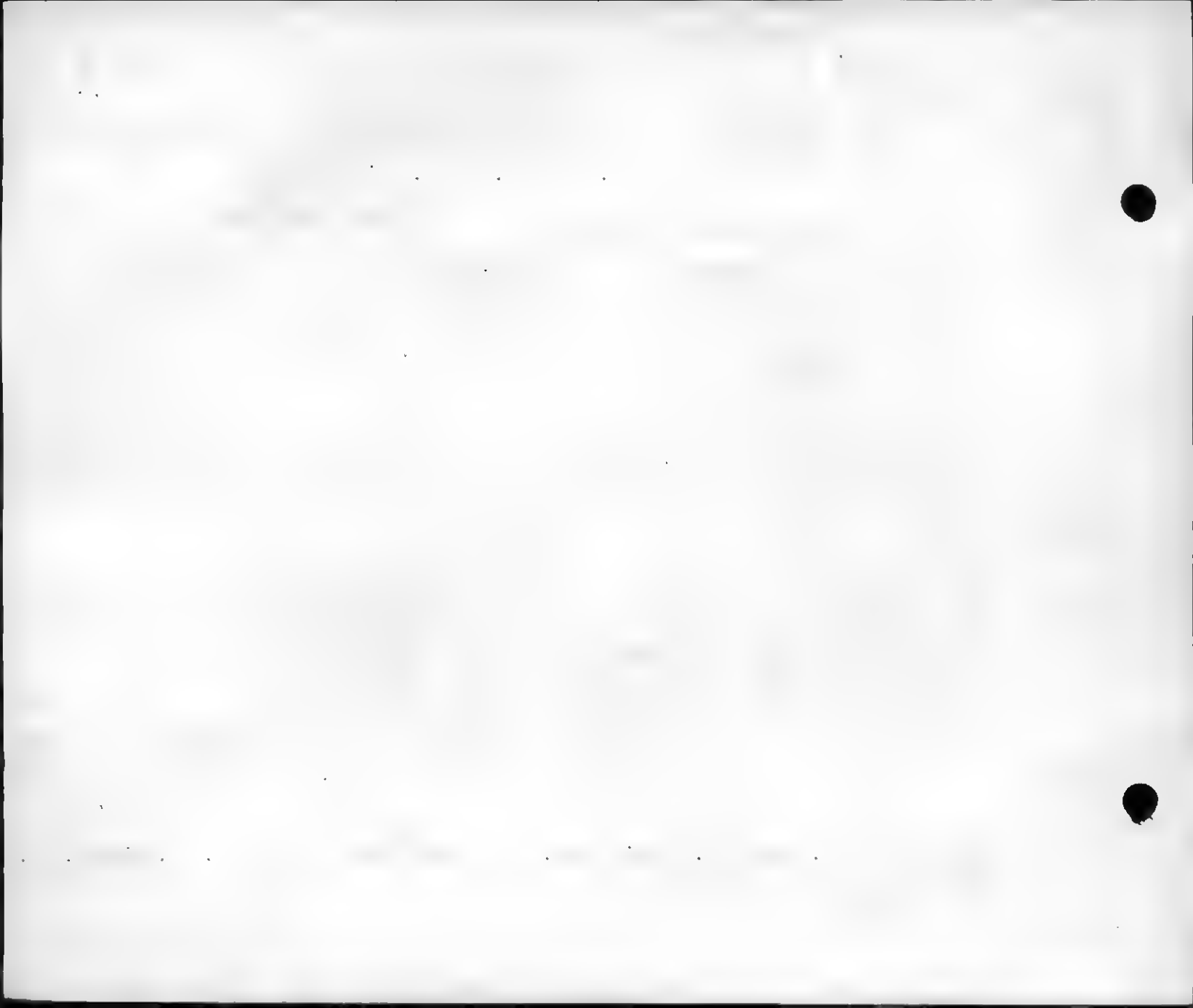
CERTIFICATE OF DEATH

15953

15944

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>3131 QueensChapel Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Morris Wishnovsky</b>		4. DATE OF DEATH Month Day Year <b>November 8 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 10, 1888</b>
9. AGE (in years lost birthday) <b>79 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Government</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-12-2257</b>	
17. INFORMANT <b>Bernard Kipperman</b>		Address <b>2205 Reedie Drive, Sil. Spg.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO <b>Diabetes Mellitus -</b> DUE TO <b>Generalized Atherosclerosis -</b> last (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs -</b> <b>3 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11/1</b> , 19 <b>67</b> , to <b>11/8</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>11/8</b> , 19 <b>67</b> , and that death occurred at <b>5 P.</b> M., from causes and on the date stated above			
22a. SIGNATURE <b>George S. Banning Jr.</b> M.D.		22b. DATE SIGNED <b>11/9/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. George S. Banning, Jr.</b>		22d. ADDRESS <b>3408 Rhode Island Ave., Mt. Rainier, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/10/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Capital Hebrew</b>	23d. LOCATION (City or Town) (County) (State) <b>Hillside Md.</b>
24. FUNERAL DIRECTOR <b>Donald M. Stein</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 13 1967</b>	
ADDRESS <b>232 Carroll Wash. DC 20012</b>		25b. REGISTRAR'S SIGNATURE <b>Richard Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MD 954

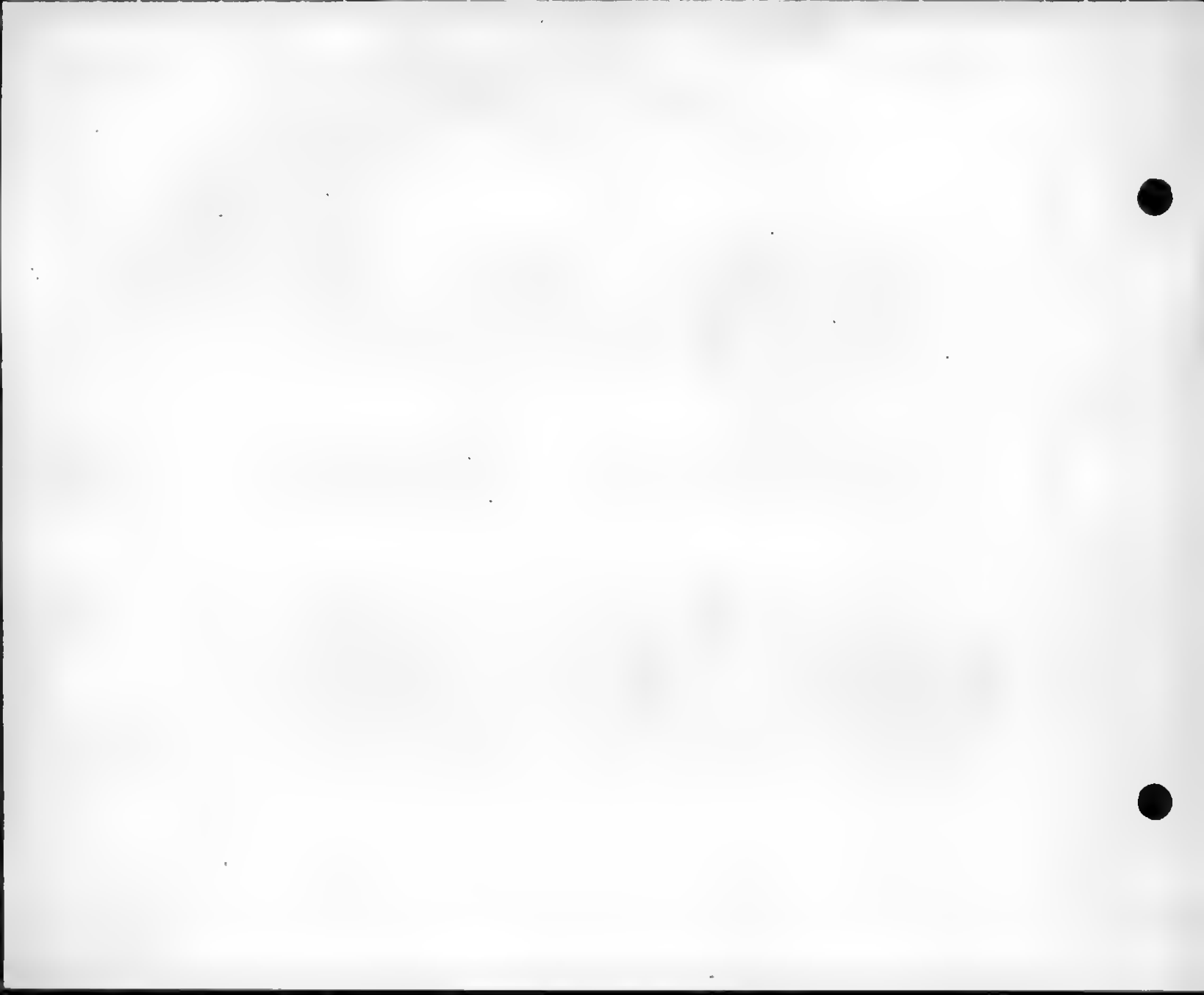
15845

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENBELT</u>		c. LENGTH OF STAY IN 1b <u>22 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREENBELT CLINICAL CENTER</u>				d. STREET ADDRESS <u>0470 51st Av.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANKLIN K. WOODRUFF</u>				4. DATE OF DEATH Month Day Year <u>Nov 24 1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/3/87</u>	9. AGE (In years last birthday) <u>79</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OIL</u>		11. BIRTHPLACE (County & State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>FRANKLIN A. WOODRUFF</u>				14. MOTHER'S MAIDEN NAME <u>LINDA PUTTER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>107-14-3263</u>		17. INFORMANT Address <u>Linda Moffat College Park, Ind</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decomposition</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>year</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 7, 1967</u> to <u>11-24, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-24, 1967</u> and that death occurred at <u>5:20</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Wm. Weintraub</u>				22b. DATE SIGNED <u>Nov. 24 - 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Wm. Weintraub</u>	
22d. ADDRESS <u>Greenbelt, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov 27, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pro Geo Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15946

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b six hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS Brooks Road	
3. NAME OF DECEASED (Type or print) First Middle Last James Daniel Wright		4. DATE OF DEATH Month Day Year 11 17 19 67	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-14
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME James Ernest Wright		14. MOTHER'S MAIDEN NAME Mary E. Curtis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 597-28-1069	
17. INFORMANT Eleanor Wright		18. ADDRESS 901-67 Ave. N.E. Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 332x IMMEDIATE CAUSE (a) Cerebro vascular occlusion DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 11-19-67	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-20-67	
23c. NAME OF CEMETERY OR CREMATORY St. Philips Ch. Cemetery		23d. LOCATION (City or Town) (County) (State) Aguasco Pr. Geo. Md.	
24. FUNERAL DIRECTOR Martell Adams		25. REC'D BY REGISTRAR DATE NOV 22 1967	
25b. REGISTRAR'S SIGNATURE James Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.


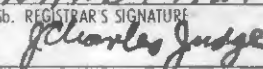
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15956

CERTIFICATE OF DEATH

15947

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Andrews</b>			c. LENGTH OF STAY IN 1b <b>24 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bryan Road</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Malcolm Grow USAF Hosp</b>				d. STREET ADDRESS <b>412 Amhurst Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Mason</b> Last <b>Zeigler SR.</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>30</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 29, 1895</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paint</b>		11. BIRTHPLACE (County & State, or foreign country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Theadore Zeigler</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Sullivan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II 372-07-9038</b>		17. INFORMANT <b>11305 Keystone Ave William E. Zeigler Clinton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASHD with Renal Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>7 Nov</b> , 19 <b>67</b> , to <b>30 Nov</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>30 Nov</b> , 19 <b>67</b> , and that death occurred on <b>11:00 PM</b> causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED <b>30 Nov 67</b>		22c. PHYSICIAN'S NAME (Type) <b>RUBEN ALTMAN, CAPT USAF MC</b>	
22d. ADDRESS <b>Malcolm Grow USAF Hosp Andrews AFB</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)				
<b>BURIAL</b>	<b>12/4/1967</b>	<b>CEDAR HILL</b>	<b>SUITLAND, MD.</b>				
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO. INC.</b>		25a. REC'D BY REGISTRAR <b>DEC 4 1967</b>		25b. REGISTRAR'S SIGNATURE 			

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By Day

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